otogenetics® corporation

Medicare Genetic Test Requisition Gx™

Please submit both pages of this form.

LABORATORY USE ONLY:	DATE RECEIVED:	ACCESSION NO:	SPECIMEN ID:

1. PATIENT INFORMATION (REQUIRED)

First Name____________________ Last Name_______________________
DOB(mm/dd/yyyy) _________________ ☐ Male ☐ Female Age_____
Address____
City_____________________ State________ Zip Code _______________
Phone ____________________ Email______________________________

2. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_______________ Last Name_________________________
Medical Credentials________ NPI#____________________________
Facility Name____
Address____
City_________________________ State________ Zip____________
Direct Office Contact (Required) ______________________________
Phone____

3. ADDITIONAL RESULTS RECIPIENT

Healthcare Professional Name ____________________________________
Phone______________________ Fax______________________________
Email (for notification of results only)____________________________
Mailing Address____
City___________________________ State_______ Zip________________

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection______________ Collected By__________________
Specimen Type ☐ Saliva ☐ Blood (Lavender Top)

5. MEDICARE CRITERIA – Please complete the Medicare Criteria Section on the Reverse Side of this Form

Medicare does not currently cover the cost of genetic testing in individuals who do not have a personal history of cancer.
Medicare may deny a second test order as a Reflex test. Otogenetics will contact providers if an ABN is required for reflex tests.
Please feel free to contact us at 855-686-4363 with any questions.

6. ANCESTRY (Select all that apply)

☐ African/African American
☐ Ashkenazi Jewish
☐ Caucasian
☐ East Indian
☐ French Canadian
☐ Hispanic/Latin American
☐ Mediterranean
☐ Middle Eastern
☐ Native American
☐ Pacific Islander
☐ Sephardic Jewish
☐ South East Asian
☐ Other

7. ICD10 CODES: _________________________________
____

8. TEST PANELS

9. PATIENT INFORMED CONSENT (Please sign here or the consent form)

☐ I have read the Informed Consent Form and give permission to Otogenetics to perform the genetic tests as described.
☐ **Optional**: I consent to use of my de-identified test samples for research.
☐ **Optional**: I consent to be contacted by Otogenetics for research opportunities.
☐ **Optional**: I am a New York State resident and I consent to storing my test samples at Otogenetics beyond 60 days for future use or testing

Patient Signature Date

10. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine the patient's medical management and treatment decision. The person listed as the Ordering Physician is legally authorized to order the test(s) requested herein. The patient was provided with information about genetic testing and has consented to genetic testing.

Ordering Physician Signature_________________________ Date__________

11. PATIENT PAYMENT OPTIONS

INSURANCE: Please attach a copy of front and back of insurance card

I am covered by insurance and understand and authorize:

- Otogenetics to give my health insurance plan information on this form and other information provided by my healthcare provider that is necessary for reimbursement.
- Otogenetics to inform my plan of my test result only if required for preauthorization or payment of additional or reflex testing.
- Plan benefits to be payable to Otogenetics.

Patient Signature ______________________Date__________

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