Greenwood Genetic Center

Cytogenetics Request Form

106 Gregor Mendel Circle • Greenwood, SC 29646
Toll Free: (800) 473-9411 • Fax: (864) 941-8141
Website: www.ggc.org Highlighted boxes are required

LAB USE ONLY

Patient Information (Please Print):

Last Name First MI		Address	
Race/Ethnicity	Sex ☐ M ☐ F	DOB MM/DD/YYYY	City, State, Zip
Specimen Collection Date MM/DD/YYY	Type of specimen	Numeric Identifier (Medical record # or SSN)	Home telephone

Referring Physician:

Name		Address	
Institution		City, State, Zip	
NPI#		Telephone	Fax
Email Address:		Preferred Method to Receive Results: ☐ Secure Email ☐ Fax ☐ Regular Mail	

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name			Address
Telephone	Fax	Email:	City, State, Zip

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name			Address
Telephone	Fax	Email:	City, State, Zip

Billing: Select how the test(s) will be billed & complete the billing information on the next page. The BILLING FORM on page 2 is required.

☐ **Institutional Billing: Complete section 1 on the separate BILLING FORM (page 2)**

☐ **Insurance: Complete section 2 on the BILLING FORM (page 2). No out-of-state (non-SC) insurance or Medicaid will be accepted.**

☐ **Self-pay: Complete section 3 on the separate BILLING FORM (page 2).**

Indication For Study & Clinical Information:

☐ ICD10 Code(s): _____

☐ Symptomatic, specific findings: _____

☐ Family History _____

Is the patient currently pregnant? ☐ No ☐ Yes If so, provide LMP: _____ or EDC: _____ Gestational Age: _____

Ultrasound findings_____

Please attach pedigree

CHROMOSOME STUDIES ●*
- ☐ High resolution chromosomes
- ☐ High resolution chromosomes, rule out mosaic
- ☐ Routine blood chromosomes
- ☐ Routine blood chromosomes, rule out mosaic
- ☐ Routine blood chromosomes, short study
- ☐ Solid tissue chromosomes

AMNIOTIC FLUID STUDIES *
- ☐ Chromosomes
  - ☐ AFP ☐ AChE (Sendouts)
- ☐ Trisomy Screen – FISH (13,18,21,X,Y)

CHORIONIC VILLUS SAMPLING (CVS) *
- ☐ Chromosomes
- ☐ Trisomy Screen – FISH (13,18,21,X,Y)
- ☐ Maternal Cell Contamination ►**Required**

OTHER
- ☐ Bank DNA
- ☐ Cell Culture only
- ☐ Other: _____

MICROARRAY ►*
- ☐ CytoScan DX Microarray (FDA cleared/peripheral blood only)
  One or more of the following must be present:
  - ☐ Developmental delays
  - ☐ Intellectual disability
  - ☐ Congenital anomalies Specify: _____
  - ☐ Dysmorphic features Specify: _____
- ☐ CytoScan HD Microarray
- ☐ Prenatal Microarray
  Parent Samples Included:
  - ☐ Mom's sample
  - ☐ Dad's sample
- ☐ Pregnancy Loss (POC) Microarray*
- ☐ Targeted Infertility Microarray
- ☐ X Chromosome High Density Microarray
- ☐ Custom Array (725 genes)
- ☐ Custom Array, Other: _____
- ☐ Array Confirmation – Parental Studies
  Please Specify Proband: _____

FISH FOR CONGENITAL ABERRATIONS ●*
- ☐ Angelman syndrome (15q11q13)
- ☐ Autism (dup 15q12)
- ☐ Chromosome enumeration probes (all chromosomes available) Specify: _____
- ☐ Chromosome paints (all chromosomes available) Specify: _____
- ☐ Cri du chat syndrome (5p-)
- ☐ DiGeorge/VCF syndrome (22q11)
- ☐ Disorders of Sexual Development Panel
- ☐ Kallman syndrome (Xp22.3)
- ☐ Miller-Dieker syndrome (17p13)
- ☐ Prader-Willi syndrome (15q11q13)
- ☐ Smith-Magenis syndrome (17p11.2)
- ☐ (includes SRY/Xcen & X/Y dual assay probes) Steroid sulfatase (Xp22.3)
- ☐ Trisomy screen (13,18,21,X,Y)
- ☐ Williams syndrome/elastin and LIMK1 (7q11.23)
- ☐ Wolf-Hirschhorn syndrome (4p-)

► **Requires purple top tube** ● **Requires sodium heparin tube** * **Room temperature/24 hour**

LAB USE ONLY Accessioned By:		Event Codes:		FedEx BeavEx UPS Other:	
EDTA RT / R / F	Na Hep RT / R / F	Plasma RT / R / F	Urine / Flasks / Other RT / R / F	Serum / Tissue RT / R / F	DBS / DNA RT / R / F

Greenwood Genetic Center

Diagnostic Laboratory Billing Form

This page is required to process any test requests.

LAB USE ONLY

- **Out of State (non-SC) commercial insurance can only be filed for NGS Panels.**
- **No out of state Medicaid will be accepted for any tests.**
- **The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.**
  - ☐ **This form must be completed with ALL requested information.**
  - ☐ **A legible copy of both sides of the insurance card**
  - ☐ **Authorization number, authorization letter, or letter of agreement from insurance company**

Patient Information:

Last Name First MI		Address	
Numeric Identifier (Medical record # or SSN)	DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)			

Section 1: Institutional Billing

Complete section below with institution information. *New clients must complete an INSTITUTIONAL ACCOUNT REQUEST FORM when submitting the order.* Please contact the GGC Billing Office at 864-941-8117 or billing@ggc.org with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

Section 2: Insurance Information INSURANCE OR MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED

MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
All information required to file insurance claims.

Primary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

Secondary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name:_____ Signature:_____ Date (MM/DD/YY):_____

Section 3: Self-pay

We accept check/Visa/MasterCard. All information required to process credit card payments.
Payments will be processed prior to initiation of testing.

Payment Method: ☐ Check ☐ Visa ☐ MasterCard	Credit Card Number:	
Amount: (with discount applied if applicable)	Exp. Date	CVV
Cardholder Name(print as it appears on the card):	Cardholder Signature:	Date
Billing address	City, State, Zip	Telephone