Oncology Testing Request Form

Greenwood Diagnostic Labs
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

*DNA samples only: Please identify where DNA extraction was performed.
☐ **CAP/CLIA Accredited Lab:** _____ ☐ **Research Lab:** _____ ☐ **Unknown**

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: Please attach pedigree

☐ ICD10 Code(s): _____

☐ Symptomatic, specific findings: _____

HEMATOLOGY/ONCOLOGY CYTOGENETIC STUDIES CHROMOSOME ANALYSIS

- ☐ Bone marrow *
- ☐ Stimulated/Unstimulated blood●
  Specify WBC count: _____
- ☐ Lymph Nodes ^

FISH PANELS ●*

- ☐ Acute Lymphocytic Leukemia (ALL) ^
- ☐ Acute Myelocytic Leukemia (AML) ^
- ☐ Acute Promyelocytic Leukemia (APL)
- ☐ Chronic Lymphocytic Leukemia (CLL) ^
- ☐ Chronic Myelocytic Leukemia (CML)
- ☐ Chronic Myelomonocytic Leukemia (CMML)
- ☐ Multiple Myeloma (MM) ^
- ☐ Myelodysplastic States (MDS)
- ☐ Non-Hodgkins Lymphoma (NHL) ^
- ☐ Pediatric Acute Lymphoblastic Leukemia (P-ALL) ^
- ☐ Reflex Panel for IgH breakapart
  Includes t(8;14), t(14;18), t(11;14)

HEMATOLOGY/ONCOLOGY CYTOGENETIC STUDIES INDIVIDUAL PROBES ●*

- ☐ ABL (9q34) ^
- ☐ ALK (2p23)
- ☐ AML1/ETO t(8;21)
- ☐ ATM (11q22.3) ^
- ☐ BCL2 (18q21) ^
- ☐ BCL6 (3q27) ^
- ☐ CCND1 xT (11q13) ^
- ☐ CDKN2A/p16 (9p21) ^
- ☐ CBFB (inv16)
- ☐ C-MYC (8q24) ^
- ☐ CSF1R (5q33-q34) ^
- ☐ D13S319 (13q14) ^
- ☐ D7S486 (7q31)
- ☐ D20S108/MYBL2 (20q12 / 20q11.2)
- ☐ ETV6/RUNX1 t(12;21) ^
- ☐ IgH (14q32) ^
- ☐ IgH/BCL2 t(14;18) ^
- ☐ IgH/CCND1 t(11;14) ^
- ☐ IgH/MYC/CEP 8 t(8;14) ^
- ☐ MLL (11q23) ^
- ☐ TP53/ p53 (17p13.1) ^

MUTATION ANALYSIS► *

- ☐ Other _____

►Requires purple top tube ● Requires sodium heparin tube * Bone Marrow ^Lymph Nodes also accepted

LAB USE ONLY Accessioned By: Event Codes: FedEx Eagle UPS DHL WC USPS Other:

EDTA	Na Hep	Plasma / Serum	Urine	Flasks / Tissue	DBS / DNA	Saliva / Swab Buccal	PAX	ACD
RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F

Greenwood Diagnostic Labs

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/American Express/Discover. All information required to process credit card payments.

Payments will be processed prior to initiation of testing.

Payment Method: ☐ Check ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover	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