



# Somatic Mosaicism Request Form

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

LAB USE ONLY

### Patient Information (Please Print):

Last Name		First	MI	Address			
Race/Ethnicity			Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB MM/DD/YYYY		City, State, Zip	
Specimen Collection Date MM/DD/YYYY		Type of specimen*		Numeric Identifier (Medical record # or SSN)		Home telephone	
*DNA samples only: Please identify where DNA extraction was performed and source of DNA (blood, fibroblasts, etc.). <input type="checkbox"/> CAP/CLIA Accredited Lab: _____ <input type="checkbox"/> Research Lab: _____ <input type="checkbox"/> Unknown							

### Referring Physician:

Name			Address				
Institution			City, State, Zip				
NPI#			Telephone			Fax	
Email Address:			Preferred Method to Receive Results: <input type="checkbox"/> Secure Email <input type="checkbox"/> Fax <input type="checkbox"/> 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). WE DO NOT ACCEPT INSURANCE OR MEDICAID FOR NON-SC PATIENTS.
- Self-pay:** Complete section 3 on the separate [BILLING FORM](#) (page 2).

### Indication for Study & Clinical Information:

- ICD10 Code(s): \_\_\_\_\_
- Clinical findings: \_\_\_\_\_

If 2 specimens are being submitted as a primary and secondary sample, please specify the following details:

Primary specimen type: \_\_\_\_\_ primary specimen source/ location, if applicable: \_\_\_\_\_  
 Secondary specimen type: \_\_\_\_\_ second specimen source/location, if applicable: \_\_\_\_\_

- Family History \_\_\_\_\_
  - Targeted variant analysis for known mutation(s) – specify gene and alteration \_\_\_\_\_
  - Proband name (if tested at GGC): \_\_\_\_\_ Proband DOB \_\_\_\_\_ Study # \_\_\_\_\_
    - Relationship to proband: \_\_\_\_\_ Symptomatic:  Yes  No

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

Maternal Cell Contamination

Comments:

\_\_\_\_\_

\_\_\_\_\_

<b>LAB USE ONLY</b>		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	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	RT / R / F	RT / R / F



**Diagnostic Laboratory Billing Form**  
**This page is required to process any test requests.**

LAB USE ONLY

- No out of state (non-SC) insurance 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](mailto: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 WE DO NOT ACCEPT INSURANCE OR MEDICAID FOR NON-SC PATIENTS.**

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

<b>Primary</b>		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
<b>Authorization Number (attach copy of authorization letter) *Required</b>	Insurance City, State, Zip	Phone
<b>Secondary</b>		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
<b>Authorization Number (attach copy of authorization letter) *Required</b>	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: <input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AmEx <input type="checkbox"/> 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



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Last Name	First	MI	DOB	Numeric Identifier
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### Test Options:

Disorders of Somatic Mosaicism Panel

Targeted Analysis of secondary sample

Specify variant: \_\_\_\_\_

Set up back-up cell culture (will incur additional charges)

Please note that DNA extraction directly from tissue is typically recommended over DNA from cultured cells for most cases of suspected mosaicism. Please contact the lab to discuss specific case details and determine the most appropriate specimen type.

### Specimen Requirements:

Submission of affected tissue is strongly recommended to increase sensitivity for detecting mosaic variants. Testing includes submitting up to two different sample types. Specifically, a primary sample will be run on the NGS panel, and a secondary sample, if submitted, can be used for targeted testing if an alteration is found in the primary sample.

The preferred sample will vary by patient depending on their clinical presentation. All the following are acceptable sample types. Please contact the laboratory to discuss your patient if you have additional question.

**Fresh tissue** should be placed in screw-capped, sterile container with sterile media or alternatively Hank's balanced salt solution, or physiologically normal saline.

**Fresh whole blood or frozen peripheral blood** (3-5 ml) collected in an EDTA (lavender top) tube.

**Formalin-Fixed Paraffin Embedded** (FFPE) tissue is accepted.

**Cultured tissue** is accepted but is not the preferred sample type.

**Saliva or saliva swabs** are also accepted for this test. Saliva samples must be submitted in an approved saliva kit. Contact the lab to receive a saliva kit or to have one sent to your patient.

### Specimen Transport Instructions

**Fresh tissue or fresh whole blood** should be kept at room temperature *if it will be transported immediately*.

If specimen is not being immediately transported to the laboratory, it may be refrigerated. Specimen should be sent by courier or overnight mail.

**Frozen tissue or frozen peripheral blood** should be shipped in an insulated container on dry ice via overnight shipping. Please note that freeze/thaw cycles can impact DNA quality and should be avoided. Frozen tissue will not be viable for culture if requested.

**FFPE tissue** can be shipped overnight at ambient temperature. FFPE tissue will not be viable for culture if requested.

**Saliva or saliva swabs** are stable at room temperature and can be delivered via overnight or ground shipping.