



Biochemical Diagnostic 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 <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		

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:

Institutional Billing: Complete section 1 on the separate [BILLING FORM](#) (page 2)

Insurance: Complete section 2 on the [BILLING FORM](#) (page 2). Insurance or Medicaid for out-of-state (non-SC) patients is not accepted.

Self-pay: Complete section 3 on the separate [BILLING FORM](#) (page 2).

Indication for Study & Clinical Information:

<input type="checkbox"/> ICD 10 Code(s): _____ <input type="checkbox"/> Symptomatic, specific findings: _____ <input type="checkbox"/> Family History _____ <input type="checkbox"/> Medications or treatment: _____ Is the patient currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, provide LMP date: _____ or EDC: _____ Please attach pedigree	Is this patient currently on enzyme replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, name of therapy: _____ Has this patient had a stem cell transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date of transplant: _____ Has this patient had a blood transfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date of transfusion: _____ If so, type of transfusion: <input type="checkbox"/> PRBC <input type="checkbox"/> FFP <input type="checkbox"/> Platelets Previous Testing: _____
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General sample and shipping requirements ****Please note that accepted sample types are specific to the individual test(s) being requested.****

- Dried Blood Spot (D)** - Fill at least 3 circles completely with a single layer of blood for each circle. Additional shipping instruction can be found on each test's webpage.
- Fibroblasts (F)** - Fresh tissue should be placed in transport media (preferred) or sterile saline and shipped overnight. For cultured tissue, please send two T25 flasks overnight. If cultured tissue is being sent, a control flask is requested in addition to the patient sample.
- Leukocytes (L)** - Blood in sodium heparin (green top) tube, must arrive within 24 hours of draw. Ship overnight at room temperature.
- Plasma (P)** - Sodium heparin (green top) tube. Ship whole blood overnight at room temperature OR spin down, remove plasma, and send plasma frozen.
- Serum (S)** - Red top tube. Ship whole blood overnight at room temperature OR spin down, remove serum, and send serum frozen.
- Urine** - Send frozen.
- Whole blood (WB)** - Blood in sodium heparin (green top) tube, must arrive within 24 hours of draw. Ship overnight at room temperature.

For molecular testing of metabolic genes, please complete a [Molecular Lab Request Form](#).
 Prenatal molecular studies require prior approval. Please contact the lab for specimen requirements.

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	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

- 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 <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	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone
Secondary		
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	
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: <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	

Last Name	First	MI	DOB	Numeric Identifier (Medical record # or SSN)
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**ANALYTES
Panels**

- Storage Disease Panel** – urine
Includes: MPS analysis (quantitative HS/DS/CS/KS & GAGs), Oligosaccharides analysis, and Sialic Acid, total and free

Individual Analytes

- Acylcarnitine Profile (Plasma)
- Amino Acid Analysis (Plasma)
- Amino Acid Analysis (Urine)
- Amino Acid Analysis (CSF)
- C5-DC (Glutaryl carnitine) Analysis (Urine)
- Carnitine Analysis, Total and Free (Plasma)
- Creatine Biosynthesis Disorders: Creatine/GAA (Plasma)
- Creatine Biosynthesis Disorders: Creatine/GAA (Urine)
- Creatine Transporter Deficiency: Creatine Analysis (Urine)
- Galactose-1-phosphate (red blood cells, sodium heparin tube)
- Homocysteine Analysis (Plasma)
- MPS urine analysis (quantitative HS/DS/CS/KS & total GAGs)
- Oligosaccharide Urine Analysis
- Organic Acid Analysis (Urine)
- Orotic Acid Analysis (Urine)
- Sialic Acid Analysis, Total and Free (Urine)
- Total Glycosaminoglycans (GAGs) Analysis (Urine)
- Tryptophan Analysis (Plasma)

MONITORING TESTS

Alpha-mannosidosis

- Alpha-mannosidosis Serum Oligosaccharide Analysis

Gaucher, Niemann-Pick A/B

- Chitotriosidase Enzyme Analysis - plasma

Krabbe Disease

- Psychosine – DBS

Mucopolysaccharidoses

- Hurler/Hunter Syndrome (MPS I/II): Urine (Total GAGs, DS, HS)
- Maroteaux-Lamy Syndrome (MPS VI): Urine (Total GAGs, DS)
- Morquio Syndrome (MPS IV): Urine (Total GAGs, KS, CS)
- Sanfilippo Syndrome (MPS III): Urine (Total GAGs, HS)
- Sly Syndrome (MPS VII): Urine (Total GAGs, DS, CS)

Pompe Disease

- Glucose tetrasaccharide (Glc4) – urine

- DNA Banking – requires purple-top (EDTA) tube

- Other _____

ENZYME PANELS

- Hydrops Enzyme Panel – 4 enzymes** (skin fibroblasts only)
Gaucher, GM1 gangliosidosis, Sialidosis, & Sly syndrome
- Lysosomal Storage Disease Enzyme Panel – 13 enzymes** (WB)
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fabry, Fucosidosis, Gaucher, GM1 gangliosidosis, Hurler, Krabbe, Metachromatic Leukodystrophy, Niemann-Pick A/B, Schindler, & Tay-Sachs/Sandhoff
- Morquio Syndrome (MPS IV) Enzyme Panel – 2 enzymes** (WB, L, D)
MPS IV A & B
- Mucopolipidosis II/III Enzyme Panel (Plasma) – 3 enzymes** (WB, P)
Alpha-fucosidase, Beta-glucuronidase, Hexosaminidase
- Mucopolysaccharidosis (MPS) Enzyme Panel – 10 enzymes** (WB)
MPS I, II, III A-D, IV A & B, VI and VII *requires 2 green tops
- Multiple Sulfatase Deficiency Enzyme Panel – 3 enzymes** (WB, D)
Arylsulfatase B, Iduronate-2-sulfatase, & N-acetylgalactosamine-6-sulfatase
- Neurological Enzyme Panel – 9 enzymes** (WB)
Fabry, Gaucher, GM1 gangliosidosis, Krabbe, Metachromatic Leukodystrophy, Neuronal Ceroid Lipofuscinosis 1 & 2, Niemann-Pick A/B, & Tay-Sachs/Sandhoff
- Oligosaccharidoses Enzyme Panel – 6 enzymes** (WB, L, D)
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fucosidosis, GM1 gangliosidosis, & Schindler
- Sanfilippo Syndrome (MPS III) Enzyme Panel – 4 enzymes** (WB, F)
MPS III A-D

ENZYME PANELS – DRIED BLOOD SPOTS

- Lysosomal Storage Disease Enzyme Panel (DBS) – 12 enzymes (D)**
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fabry, Fucosidosis, Gaucher, GM1 gangliosidosis, Krabbe, Niemann-Pick A/B, Neuronal Ceroid Lipofuscinosis 2, Pompe, & Schindler
- Mucopolipidosis II/III Enzyme Panel (DBS) – 4 enzymes (D)**
Acid sphingomyelinase, Alpha-iduronidase, Alpha-mannosidase, & Beta-glucosidase
- Mucopolysaccharidosis (MPS) Enzyme Panel (DBS) – 7 enzymes (D)**
MPS I, II, III B, IV A & B, VI and VII

INDIVIDUAL ENZYMES

(whole blood accepted for all individual enzymes except sialidosis)

- Alpha-mannosidosis: α -mannosidase L,F,D
- Aspartylglucosaminuria: Aspartylglucosaminidase P,L,D
- Beta-mannosidosis: β -mannosidase L,F,D
- Biotinidase Deficiency: Biotinidase P,S
- Fabry Disease: α -galactosidase P,L,F,D
- Fucosidosis: α -fucosidase L,F,D
- Gaucher Disease: β -glucosidase L,F,D
- GM1 Gangliosidosis: β -galactosidase L,F,D
- Hunter Syndrome (MPS II): Iduronate-2-Sulfatase P,L,F,D
- Hurler Syndrome (MPS I): α -iduronidase P,L,F,D
- Krabbe Disease: Galactocerebrosidase D
- Maroteaux-Lamy Syndrome (MPS VI): Arylsulfatase B L,F,D
- Metachromatic Leukodystrophy: Arylsulfatase A L,F,D
- Morquio Syndrome A (MPS IVA): N-Acetylgalactosamine-6-Sulfatase L,F,D
- Morquio Syndrome B (MPS IVB): β -galactosidase L,F,D
- Neuronal Ceroid Lipofuscinosis 1: Palmitoyl-Protein Thioesterase 1 L
- Neuronal Ceroid Lipofuscinosis 2: Tripeptidyl Peptidase 1 D
- Niemann-Pick Disease A/B: Acid Sphingomyelinase D
- Pompe Disease, Glycogen Storage Disease Type II: α -glucosidase L,F,D
- Sanfilippo A (MPS IIIA): Heparan-N-Sulfatase L,F
- Sanfilippo B (MPS IIIB): N-Acetyl- α -Glucosaminidase P,F,D
- Sanfilippo C (MPS IIIC): Acetyl CoA Glucosamine N-Acetyltransferase L,F
- Sanfilippo D (MPS IIID): N-Acetylglucosamine-6-Sulfatase L
- Schindler/Kanzaki Disease: α -N-Acetylgalactosaminidase P,L,D
- Sialidosis: α -Neuraminidase (Sialidase) F
- Sly Syndrome (MPS VII): β -glucuronidase L,F,D
- Tay-Sachs/Sandhoff Disease: β -hexosaminidase *no carrier testing P