

**Tests Required**

Test code: \_\_\_\_\_ Test name: \_\_\_\_\_  
 Specimen: \_\_\_\_\_  
 Tube: \_\_\_\_\_ Min. vol: \_\_\_\_\_

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*Red Type Indicates REQUIRED Information*

**Who should we contact with questions about this form?**

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Identification and Specimen Information**

Patient Name: \_\_\_\_\_  
 S.S. #: \_\_\_\_\_ Sex:  Male  Female  Unknown  
**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ Patient ID# \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone (day): \_\_\_\_\_ Phone (eve): \_\_\_\_\_

**Indication for Testing:**

Diagnostic (symptomatic)  Predictive (asymptomatic)  Carrier  
 Prenatal  Other Research  Clinical Study

**Date Specimen Collected:** \_\_\_\_\_

Type of Specimen:  Whole blood  Serum  Plasma  Muscle  
 CSF  Buccal Swab  CVS/Cultured  CVS/Direct  
 Amniotic fluid/Direct  Amniotic fluid/Cultured

**Requesting Physician & Other Authorized Test Result Report Recipients**

**Hospital/Lab CLIA:** \_\_\_\_\_  
 Hospital/Lab Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Physician UPIN:** \_\_\_\_\_  
 Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

If additional reports are required, please attach request on a separate sheet with the patient's signature.

**Testing Authorization and ICD-9 Code**

I warrant that the test is either: (1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or (2) that if it is not for such purpose, I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person), and includes: (a) a statement of the purpose and description of the test; (b) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; (c) a statement that the consenting person was informed about the availability and importance of further testing, physician consultation and genetic counseling, and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; (d) a general description of each specific disease or condition tested for; and (e) the person or persons to whom the test results may be disclosed.

**Medical Practitioner Signature:** \_\_\_\_\_

**ICD-9 Code:** \_\_\_\_\_

**Hospital or Laboratory Billing - Section 1**

(Required for Medicare hospital inpatients and outpatients.)

Athena Account #: \_\_\_\_\_ PO# \_\_\_\_\_  
 Contact person: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Hospital/Lab Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Patient Billing Information - Section 2**

**Commercial Insurance (if patient has insurance)**

Name of Insured: \_\_\_\_\_  
 Relationship to patient:  Self  Parent  Spouse  Other  
 Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Insurance Company Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Authorization to release information and pay benefits:**

I authorize Athena Diagnostics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I also authorize benefits under this claim to be payable directly to Athena Diagnostics. I understand I am responsible for all charges not processed by my insurance carrier within 60 days of claims submission. I guarantee payment and have completed Section 2, below. I have also provided Athena Diagnostics with a copy of my insurance card (if available).

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Commercial Insurance:** Portion not paid by insurance will be billed to you.

**BC/BS:** Will courtesy bill BC/BS; any benefits are paid directly to insured. Go to Section 3.

**Self Pay:** Test will be charged to your credit card/check processed when testing complete.

**Medicaid:** Enrolled patients are eligible to deduct 50% from Athena's list prices.

Payment is required, complete Section 3, below. Include photocopy of Medicaid card.

**Medicare:** See Section 4, below.

**Payment Information - Section 3**

Visa  Mastercard  AMEX  Discover  
 Credit card #: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Check (please attach, make payable to Athena Diagnostics, Inc.)

I authorize Athena Diagnostics to bill my credit card or process my check after testing is completed, in accordance with the terms above.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medicare - Section 4 (Per Medicare regulations, do not use if patient is hospital inpatient or outpatient. Complete Bill Hospital/Laboratory- Section 1.)**

**Medicare #:** \_\_\_\_\_

The following Physician Notice and Patient Agreement is required for Medicare patients, as some of our tests may be denied payment.

**Advance Beneficiary Notice (ABN)**

**Physician Notice**

I believe that performing the diagnostic testing indicated above may help in determining the cause of your symptoms. Medicare will only pay for services that it determines to be "reasonable and customary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment. In your case, Medicare is likely to deny payment because they may deem that the effectiveness of this testing has not yet been proven.

**Patient Agreement**

I have been notified by my physician that, in my case, Medicare is likely to deny payment for the services identified above. If denied, I authorize Athena Diagnostics to deposit my check or process my credit card, as indicated above, for charges for this testing.

Patient (or Authorized Guardian)  
 Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_