Genetics Test Requisition

MOLECULAR VISION
1920 NE Stucki Ave # 150 Hillsboro OR 97006
PHONE: 503-227-3179
FAX: 503-227-3157
EMAIL: inquiry@mvisionlab.com

PRIMARY PATIENT

LAST NAME	FIRST NAME		
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ○ Male ○ Female ○ Unknown		
ADDRESS		ETHNICITY	
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	EMAIL		
Saliva Collection Kits available by USPS priority shipping for $30 (fee waived for orders of $300 or more)			
☐ Send kit to address above ☐ Send kit to alternate address			

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME	PROVIDER FIRST NAME
NPI (USA) / MINC (CANADA)	EMAIL
PROVIDER PHONE	DELIVER REPORT TO
COLLECTION DATE (MM/DD/YYYY)	SAMPLE TYPE Blood ○ Saliva ○ Other:
MRN / Patient ID	GENETIC COUNSELOR

MEDICAL HISTORY

Fill out medical history or attach documentation

BILLING

Self Pay ○ MVL staff will email you to setup payment
Insurance ○ Attach copy of front/back of Insurance Card
Institutional ○

ICD-10 DIAGNOSIS CODE	REFERRAL/PRIOR AUTH

Institutional Only

HOSPITAL / LAB NAME	CONTACT NAME	EMAIL
PHONE NUMBER	PO# / DEPT CODE (IF USED)	ADDRESS (IF DIFFERENT)

TEST REQUESTED

	OTHER
PRICE	

If I am covered by insurance, I authorize MVL and their contracted billing company to give my insurance carrier the information on this form and provided by my healthcare provider that is necessary for reimbursement. I understand that I am responsible for deductible and coinsurance amounts as indicated by my insurance carrier. I agree to assist in resolving insurance claim issue and if I do not assist, I may be responsible for the cost of the test. I understand that I am responsible for sending MVL any and all of the money that I receive directly from my insurance carrier in payment for this test.
If the test is not authorized by or is not covered by my insurance, than I will be contacted with the option to either cancel the ordered test or elect to pay out-of pocket according to the proposed payment plan provided to me when I am contacted. If I elect to pay out-of-pocket, I will be responsible for all payment obligations arising from the ordered testing and guarantee payment for these services. I understand that if payments or arrangements are not made after 3 statements my information may be sent to collections.
MVL is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card. You may also contact our billing team at 518-702-4353.

I attest that the patient has received and read the MVL Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any MVL Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

PATIENT SIGNATURE	DATE (MM/DD/YYYY)	PROVIDER SIGNATURE	DATE (MM/DD/YYYY)
X		X	

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SECOND PAGE OPTIONAL

PATIENT BILLING INFORMATION	MVL staff will email patient for billing if this section is left blank		
NAME ON CARD	CARD NUMBER	EXPIRATION	CVV
PAYMENT AMOUNT			