

Genetics Test Requisition



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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	

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:

<p>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.</p> <p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>		
PATIENT SIGNATURE X	DATE (MM/DD/YYYY)	PROVIDER SIGNATURE X	DATE (MM/DD/YYYY)