GENETIC ASSAYS
A Molecular Diagnostics Laboratory
4711 Trousdale Drive, Suite 209 • Nashville, TN 37220
615-781-0709 • Fax 615-781-0766 • 800-390-5280
www.geneticassays.com

For Genetic Assays Use Only

Accession #: _____

Date Received: _____ Time Received: _____

Technician: _____ Specimen/Volume: _____

Client Information

Account #
Client Name
Address
City, TN Zip
Ph: (615) Fx: (615)

❑ Call ❑ Fax Results to _____

Patient Information

Patient's Name: _____
(Last, First, MI)

Patient/Specimen I.D.#: _____

Sex: _____ Date of Birth: _____ Age: _____

Date Collected: _____ Time Collected: _____

Specimen Type: _____

Physician: _____ NPI#: _____

ICD-10 Code (**MUST BE PROVIDED**): _____

Billing Information

❑ **Bill Client Directly** ❑ **Bill Insurance -** *Provide info below or attach copy of insurance card (front **and** back) and demographic sheet.*

Insurance Company: _____

ID #: _____ Group #: _____

Subscriber Name: _____ DOB: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone #: _____

Patient Relationship to Insured: ❑ Self ❑ Spouse ❑ Other _____

Patient's Social Security: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

FOR MEDICARE PATIENTS: I authorize any holder of medical or other information about me to release to the health care financing administration or its intermediaries or carriers or any other government agency or insurance carrier responsible for payment, any information needed for this or related Medicare or other claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment shown; **(Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (1) of the Medicare Law. There may be certain molecular genetic tests that are ordered which your physician feels are necessary for the maintenance of good health that are not covered by your insurance contract. You will be expected to pay for those services in full.)** I have read your policy and agree to pay for services not covered by my contract as indicated by my signature. I understand that my doctor has ordered molecular genetic tests to be performed by Genetic Assays, Inc. Laboratory.

Medicare Patient's Signature: _____ Date: _____

Frequently Requested Assays: *For additional testing needs, please call Client Services.*

3701 ❑ **Adenovirus** DNA by Real-time PCR (Quantification)

824 ❑ **Bacterial Vaginosis Panel** by PCR

3700 ❑ **BK Virus** DNA by Real-time PCR (Quantification)

3333/0180 ❑ ***C. trachomatis & N. gonorrhoeae*** by TMA

3333 ❑ ***Chlamydia trachomatis*** by TMA

0180 ❑ ***Neisseria gonorrhoeae*** by TMA

2682 ❑ **COVID-19 (SARS CoV-2)** by RT-rPCR

6262 ❑ **Cystic Fibrosis Mutation Detection**

Racial/Ethnic Background *(Required)* _____

Indications for Testing *(Please check)*

- ○ Confirmatory Diagnostic Testing
- ○ Carrier Testing, general population of reproductive couples
- ○ Carrier Testing, positive family history ❑Yes ❑No ❑Unknown

IF YES, please list known mutations: _____

3702 ❑ **Cytomegalovirus (CMV)** DNA by Real-time PCR (Quantification)

6111 ❑ **Epstein-Barr Virus (EBV)** DNA by Real-time PCR (Quantification)

7667 ❑ **Gastrointestinal Pathogen Panel (GPP)** by multiplex RT-PCR

900 ❑ **HSV-1&2** DNA by Real-time PCR

250 ❑ **Mycobacteria** DNA by PCR

275 ❑ **Mycobacteria** DNA by PCR w/ **AFB Stain & Culture**

787 ❑ **PharyngoTonsillitis Panel (PTP)** by Real-Time PCR

2019 ❑ **Respiratory Virus & Bacteria Panel (RVBP)** by multiplex RT-PCR

301 ❑ **STD3 Panel** by PCR (CT/NG, Trich)

501 ❑ **STD5 Panel** by PCR (CT/NG, Trich, HSV-1&2)

8425 ❑ **Tick-Borne Ehrlichiosis Panel** by Real-time PCR

101 ❑ ***Trichomonas vaginalis*** DNA by PCR

Write in test code # and test name below *(For additional tests)*

_____ _____