BRAC*Analysis*®

Powered by myVision™

MYRIAD

MYRIAD GENETIC LABORATORIES, INC.
A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, Utah 84108
(800) 469-7423 • (801) 584-1100
Fax (801) 584-3615 • info@myriad.com

Test Request Form and Statement of Medical Necessity

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

SPECIMEN COLLECTION DATE (REQUIRED)

NOTE: Affix Bar Code Label to Specimen Tube

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE) NPI #

MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800)469-7423)

ADDRESS CITY STATE ZIP

OFFICE CONTACT PHONE FAX

SEND RESULTS TO (IF OTHER THAN ORDERING PHYSICIAN)

NAME (LAST, FIRST, DEGREE) NPI #

MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800)469-7423)

ADDRESS CITY STATE ZIP

OFFICE CONTACT PHONE FAX

PATIENT INFORMATION (COMPLETE INFORMATION REQUIRED FOR INSURANCE COVERAGE)

PATIENT NAME (LAST, FIRST, INITIAL) PATIENT ID# ☐ FEMALE ☐ MALE BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS CITY STATE ZIP DAYTIME PHONE NUMBER E-MAIL ADDRESS

ANCESTRY AND CLINICAL HISTORY

☐ WESTERN/NORTHERN EUROPE ☐ CENTRAL/EASTERN EUROPE ☐ AFRICA ☐ NEAR EAST/MIDDLE EAST
☐ ASHKENAZI ☐ LATIN AMERICAN/CARIBBEAN ☐ ASIA ☐ NATIVE AMERICAN ☐ OTHER _____

PATIENT PERSONAL HISTORY OF CANCER *(Check all that apply)*

☐ NO PERSONAL HISTORY OF CANCER
☐ BREAST, INVASIVE/AGE AT Dx: _____
☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-, PR-, HER2- pathology)
☐ BREAST, DCIS/AGE AT Dx: _____
☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-, PR-, HER2- pathology)
☐ OVARY/AGE AT Dx: _____
☐ OTHER: _____ AGE AT Dx: _____
☐ BONE MARROW TRANSPLANT RECIPIENT
☐ CURRENT DIAGNOSIS OF A HEMATOLOGIC CANCER
☐ ICD-9 CODE(S)/Dx: _____

FAMILY HISTORY OF CANCER *(Please Indicate Relationship, Maternal or Paternal, Site of Cancer, Age at Diagnosis) (Please Indicate if Bilateral, Premenopausal, or Triple Negative Breast Cancer)*

☐ NO KNOWN FAMILY HISTORY

RELATIONSHIP	MATERNAL	PATERNAL	CANCER SITE	AGE AT Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

TESTS REQUESTED

☐ **Integrated BRAC*Analysis*** – *BRCA1* and *BRCA2* gene sequence and large rearrangement analysis for susceptibility to Hereditary Breast and Ovarian Cancer syndrome (Large rearrangement analysis may be reported and billed independently, and insurance coverage may vary based on payor criteria; certain payors may require reflex testing)

☐ **Multisite 3 BRAC*Analysis*** – Three-mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry (187delAG, 5385insC, 6174delT)

☐ **REFLEX** to Integrated BRAC*Analysis* if the Multisite 3 is negative ☐ **Check** here if a family member has tested positive for one of the above three mutations

☐ **Single Site BRAC*Analysis*** – Mutation-specific analysis for individuals with known *BRCA1* or *BRCA2* mutations in their family

Specify Gene: ☐ *BRCA1* ☐ *BRCA2* **Specify Variant (Mutation)**: _____

Relationship: My patient is the _____ (e.g., maternal aunt) of the known mutation carrier. **Required: Include a copy of the known mutation carrier's report.**

☐ **Other**: _____

INFORMED CONSENT AND STATEMENT OF MEDICAL NECESSITY

I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder, and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.
(NOTE: For Medicare patients, please complete the enclosed Informed Consent Form)
(NOTE: Test requests without a signature will not be processed)

_____ MEDICAL PROFESSIONAL SIGNATURE _____ DATE

BILLING/PAYMENT INFORMATION

☐ OPTION 1: PLEASE BILL MY INSURANCE *(Option 1 requires patient signature and enlarged copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary)*

Name of Policy Holder: _____ DOB: _____ Insurance ID#: _____

Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Authorization/Referral #: _____

(Please attach copy of authorization/referral)

I hereby represent that I am covered by insurance and authorize Myriad Genetic Laboratories, Inc. (MGL) to furnish my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the information on this form and other information provided by my healthcare provider necessary for reimbursement. I authorize Plan benefits to be payable to MGL. I understand that MGL will contact me prior to test start ONLY if my total financial responsibility will exceed $375 (for any reason, including co-insurance and deductible, or non-covered services). If requested, I agree to assist MGL in resolving insurance claim issues and if I don't assist, I may be responsible for the full test cost. I permit a copy of this authorization to be used in place of the original. I authorize MGL to inform my Plan of my test result ONLY if it is negative and only if test results are required for preauthorization of or payment for reflex/additional testing.

REMINDER: INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S)

Patient/Responsible Party Signature: _____ Date: _____

☐ OPTION 2: PATIENT PAYMENT *(Please call Customer Service for questions regarding test prices)*

☐ Please bill my credit card (all major credit cards accepted) in the amount of $ _____ Card# _____ Exp. Date: _____

Cardholder Name (please print): _____ Cardholder Signature: _____

☐ Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.

☐ OPTION 3: OTHER BILLING *(To establish an account, submit billing information with this form)*

☐ Bill our institutional account #: _____ *or* established research project code #: _____ *or* Authorization/Voucher #: _____