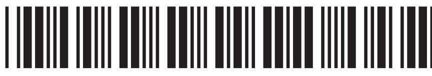

SPECIALIZED MOLECULAR/GENETIC TESTING OUTPATIENT ORDER FORM

Use this form with all Specialized Molecular and Genetic testing Requests.
Excludes: Standard Karyotypes, hematologic malignancies, cystic fibrosis, and MTHFR

Name (Last) (First) (M.I.)

Birth Date | Maiden or Previous Name | Sex ☐M ☐F

Primary Diagnosis(es), CPT Codes & ICD-10 Code(s) or Symptoms:

All orders require a signature from the provider to process
Provider Signature:______________________________
Date Time
Print Provider Name:______________________________

Clinical Indication for test *(*Required)*:
☐ **Diagnostic (Symptomatic)** ☐ **Carrier Status**
☐ **Predictive** NOTE: MI State Law requires informed consent

Ordering Physician/Provider:

Consult Copy To:

Visit/Encounter # Unit Med. Record #

SPECIMEN COLLECTION Date:_________**Time:**_________**Initials**_____

ID#:

Please contact a Mayo Genetic Counselor at: **800-533-1710** or visit www.mayomedicallaboratories.com for additional information and requirements prior to ordering test(s). Most Mayo genetic tests require a patient information form available on-line. If there is any ambiguity in the test order, we will request that you call Mayo to clarify the test name and order number.

Test(s) Ordered: (Please indicate the number of tests and list each test name and number separately) **Total number of tests:**

1. ______________________________
2. ______________________________
3. ______________________________

Responsible Party / Insured Policy Holder Information

Insured Last ______________________ Insured First______________MI:______Sex: ☐M ☐F
Insured DOB:______________________
Phone Number (if different from patient):______________________ Cell Phone:______________________
Relationship to patient:______________________ Preferred Language:______________________

Primary Insurance:
Insurance Company:______________________
Subscriber Name:______________________ Subscriber DOB:______________________
Relationship to Patient:______________________
Employer Name & Address:______________________
Policy Number:______________ Group Number:______________ Co-Pay $%:______________

Secondary Insurance:
Insurance Company:______________________
Subscriber Name:______________________ Subscriber DOB:______________________
Relationship to Patient:______________________
Employer Name & Address:______________________
Policy Number:______________ Group Number:______________ Co-Pay $%:______________
Signature:______________________ Date:______________

☐ **Self Pay** ☐ **ABN: Advanced Beneficiary Notice** ***Estimated Test Pricing:**______________
Specialized Molecular/Genetic Testing requires prior authorization.
☐ **Preauthorization requested (office use)**
***Estimated test pricing will be provided by Bronson Laboratory – 269-341-6440**

Fax completed form to Bronson Laboratory at 269-341-8423

Once authorized, specimen collection can be scheduled by calling Central Scheduling at 269-341-8700.
Specimen collection for these tests will be performed at 601 John St. location only.

For driving directions, hours of operation, and additional test information in our online test catalog, please visit www.bronsonhealth.com

9004032 (10/15)