COLARIS *AP*®

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

A Test for the Polyposis Syndromes (FAP, AFAP, MAP)

Test Request Form and Statement of Medical Necessity
TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

NOTE: Affix Bar Code Labels to Specimen Tubes

SPECIMEN COLLECTION DATE (REQUIRED): 04/10/13

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE): Physician, Bob, MD
NPI #: 3456789012
MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800)469-7423): 12345
ADDRESS / CITY / STATE / ZIP:
OFFICE CONTACT: Shirley Tate
PHONE: 222-222-2222
FAX: 222-222-2223

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): Doe, Jane T
PATIENT ID#: 00000
☒ FEMALE ☐ MALE
BIRTH DATE (MM/DD/YYYY): 09/10/1954
STREET ADDRESS: 123 Generic Street
CITY: This City
STATE: ST
ZIP: 45678
DAYTIME PHONE NUMBER: 222-000-0000
E-MAIL ADDRESS: janedoe@email.com

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)*

☒ ICD-9 Code(s)/Dx: 211.3, V19.8 (or applicable codes)
☐ No Personal History of Adenoma
☐ Colorectal Invasive* Age at Dx: _____ ☐ MSI-H Histology (see below):
☐ Mucinous ☐ Signet Ring ☐ Medullary Growth Pattern
☐ Tumor Infiltrating Lymphocytes ☐ Crohn's-like Lymphocytic Reaction
☒ Adenomatous Polyps Age at Dx of First Adenoma(s): 27
Cumulative #: ☐ 1 ☐ 2-5 ☐ 6-9 ☒ 10-19 ☐ 20-99 ☐ 100+
☐ Other: _____ Age at Dx: _____
☐ Bone Marrow Transplant Recipient
*If MSI/IHC testing was performed, please provide results: _____

FAMILY HISTORY OF CANCER *(Please Indicate Relationship, Maternal or Paternal, Site of Cancer or Adenoma Number, Age at Diagnosis)*

☐ NO KNOWN FAMILY HISTORY

RELATIONSHIP	MATERNAL	PATERNAL	CANCER SITE	AGE AT Dx	ADENOMA NUMBER	AGE AT Dx
Father	☐	☒	Colon	48	15	48
Cousin	☐	☒			20	39
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

TESTS REQUESTED (FOR DETAILED INFORMATION ABOUT THESE TESTS, PLEASE SEE BACK OF THIS FORM)

INITIAL TESTING FOR POLYPOSIS SYNDROMES (FAP, AFAP, MAP)

☒ **COMPREHENSIVE COLARIS *AP*** *(Analysis of APC and MYH)*

OTHER TESTS

☐ **SINGLE SITE TESTING** *(For family of known mutation carriers)* **Specify Gene**: _____ and Mutation: _____
Relationship: My patient is the _____ (eg, maternal aunt) of the known mutation carrier. **Include a copy of the known mutation carrier's report, if available.**
☐ **GENE-SPECIFIC TESTING** *(Please specify)*: _____
☐ **OTHER:** _____

INFORMED CONSENT AND STATEMENT OF MEDICAL NECESSITY

I have supplied information to the patient regarding genetic testing and the patient has consented 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 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.
(NOTE: For Medicare patients, please complete the enclosed Informed Consent Form)
(NOTE: Test requests without a signature will not be processed)

SIGN & DATE

Bob Physician, MD — MEDICAL PROFESSIONAL SIGNATURE
04/10/2013 — 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: JANE DOE DOB: 09/10/1954 Insurance ID #/SSN: ABC-123
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 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 understand that I may not alter any printed text in this paragraph.

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

SIGN & DATE

Patient/Responsible Party Signature: Jane Doe Date: 04/10/13

☐ **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 #: _____

COLARIS *AP*®

A genetic test for adenomatous polyposis syndromes [including familial adenomatous polyposis (FAP), attenuated FAP, and MYH-associated polyposis (MAP)]

COLARIS *AP*:

Full sequence and large rearrangement analysis of *APC* and *MYH*

Single Site Polyposis Testing:

Mutation-specific analysis for individuals with a known *APC* or *MYH* mutation(s) in the family

Gene-Specific COLARIS *AP*:

APC Gene Analysis – Full sequence and large rearrangement analysis of *APC*

MYH Gene Analysis – Full sequence and large rearrangement analysis of *MYH*

NOTE: If COLARIS® and COLARIS *AP*® are ordered on the same patient, *MYH* Analysis will only be performed once.