

Cancer Testing Request Form

106 Gregor Mendel Circle • Greenwood, SC 29646
Toll Free: (800) 473-9411 • Fax: (864) 941-8141
Website: www.ggc.org **Highlighted boxes are required**

LAB USE ONLY

Patient Information (Please Print):

Last Name		MI	Address		
Race/Ethnicity		Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB MM/DD/YYYY	City, State, Zip	
Specimen Collection Date MM/DD/YYYY	Type of specimen		Numeric Identifier (Medical record # or SSN)		Home telephone

Referring Physician:

Name		Address			
Institution		City, State, Zip			
NPI#		Telephone		Fax	
Email Address:		Preferred Method to Receive Results: <input type="checkbox"/> Secure Email <input type="checkbox"/> Fax <input type="checkbox"/> Regular Mail			

Additional report to: Genetic Counselor Institution Care Coordinator Other:

Name		Address			
Telephone	Fax	Email:		City, State, Zip	

Additional report to: Genetic Counselor Institution Care Coordinator Other:

Name		Address			
Telephone	Fax	Email:		City, State, Zip	

Billing: Select how the test(s) will be billed & complete the billing information on the next page. **The BILLING FORM on page 2 is required.**

- Institutional Billing:** Complete section 1 on the separate [BILLING FORM](#) (page 2)
- Insurance:** Complete section 2 on the [BILLING FORM](#) (page 2). No out-of-state (non-SC) insurance or Medicaid will be accepted.
- Self-pay:** Complete section 3 on the separate [BILLING FORM](#) (page 2).

Indication For Study & Clinical Information:

- ICD10 Code(s): _____
- Symptomatic, specific findings: _____

HEMATOLOGY/ONCOLOGY

CYTOGENETIC STUDIES

CHROMOSOME ANALYSIS

- Bone marrow *
- Stimulated/Unstimulated blood •
- Specify WBC count: _____

Lymph Nodes

FISH PANELS •*

- Acute Lymphocytic Leukemia (ALL)
- Acute Myelocytic Leukemia (AML)
- Acute Promyelocytic Leukemia (APL)
- Chronic Lymphocytic Leukemia (CLL)
- Chronic Myelocytic Leukemia (CML)
- Chronic Myelomonocytic Leukemia (CMML)
- Multiple Myeloma (MM)
- Myelodysplastic States (MS)
- Non-Hodgkins Lymphoma (NHL)
- Pediatric Acute Lymphoblastic Leukemia (P-ALL)
- Reflex Panel for IgH breakapart
Includes t(8;14), t(14;18), t(11;14)

INDIVIDUAL PROBES •*

- 9q34
- ALK (2p23)
- AML1/ETO t(8;21)
- ATM (11q22.3)
- BCL2 (18q21)
- BCL6 (3q27)
- CCND1 xT (11q13)
- CDKN2A/p16 (9p21)
- CBFB (inv16)
- C-MYC (8q24)
- CSF1R (5q33-q34)

HEMATOLOGY/ONCOLOGY CONT.

INDIVIDUAL PROBES CONT. •*

- D13S319 (13q14)
- D7S486 (7q31)
- D20S108/MYBL2 (20q12 / 20q11.2)
- ETV6/RUNX1
- IgH (14q32)
- IgH/BCL2 t(14;18)
- IgH/CCND1 t(11;14)
- IgH/MYC/CEP 8 t(8;14)
- MLL (11q23)
- TP53/ p53 (17p13.1)

MOLECULAR STUDIES

- ARRAYS ▶ ^ ***
- Chronic Lymphocytic Leukemia (CLL) Array
Includes analysis for trisomy 21, RB1 deletions, TP53 deletions, & ATM deletions
- Acute Myelocytic Leukemia (AML) Array
Includes genomic gains, losses & LOH
- Acute Lymphocytic Leukemia (ALL) Array
Includes genomic gains, losses & LOH
- Chronic Myelocytic Leukemia (CML) Array
Includes genomic gains, losses, & LOH for cytogenetically normal CML
- OncoScan array comprehensive analysis
(any FFPE tumor tissue)

Mutation Analysis ▶ ^ *

- AML**(includes FLT-3ITD, & FLT-3TKD mutations ; NPM1 codon 12)
- Other: _____

SOLID TISSUE

MOLECULAR STUDIES

Lung Adenocarcinoma^

- EGFR amplification and mutation analysis
- BRAF mutation (V600E)
- PTEN mutation analysis
- Lung Adenocarcinoma Panel (includes EGFR amplification & mutation analysis, BRAF & PTEN mutation analysis)

Colorectal Cancer^

- KRAS mutation analysis
- NRAS mutation analysis
- Colorectal Cancer Panel (includes NRAS & KRAS mutation analysis)

Brain Tumor^

- IDH1 R132H mutation
- 1p/19q co-deletion
- NEK1 deletion
- TP53 deletion
- CDKN2A/B deletion
- EGFR amplification
- PTEN deletion
- NF1 deletion
- Adult Brain Tumor Panel
(includes 8 genes listed above)

- BRAF mutation analysis (V600E & V600K)
- Melanoma Array (includes genomic gains, losses, and loss of heterozygosity)

Lipomatous Tumors^

- Lipomatous Array (includes genomic gains Losses, and loss of heterozygosity)

▶ Requires purple top tube • Requires sodium heparin tube * Bone Marrow ^FFPE or Fresh/Frozen Tissue

LAB USE ONLY Accessioned By: _____		Event Codes: _____		FedEx BeavEx UPS Other: _____	
EDTA RT / R / F	Na Hep RT / R / F	Plasma RT / R / F	Urine / Flasks / Other RT / R / F	Serum / Tissue RT / R / F	DBS / DNA RT / R / F



Greenwood Diagnostic Labs Diagnostic Laboratory Billing Form

This page is required to process any test requests.

LAB USE ONLY

- Out of State (non-SC) commercial insurance can only be filed for NGS Panels.
- No out of state Medicaid will be accepted for any tests.
- The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.
 - This form must be completed with ALL requested information.
 - A legible copy of both sides of the insurance card
 - Authorization number, authorization letter, or letter of agreement from insurance company

Patient Information:

Last Name	First	MI	Address	
Numeric Identifier (Medical record # or SSN)		DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)				

Section 1: Institutional Billing

Complete section below with institution information. *New clients must complete an [INSTITUTIONAL ACCOUNT REQUEST FORM](#) when submitting the order.* Please contact the GGC Billing Office at 864-941-8117 or billing@ggc.org with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

Section 2: Insurance Information

MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
All information required to file insurance claims.

Primary		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number: (attach copy of authorization letter)	Insurance City, State, Zip	Phone
Secondary		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter)	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name: _____ Signature: _____ Date (MM/DD/YY): _____

Section 3: Self-pay

We accept check/Visa/MasterCard. All information required to process credit card payments.
Payments will be processed prior to initiation of testing.

Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Credit Card Number:	
Amount: (with discount applied if applicable)	Exp. Date	CVV
Cardholder Name(print as it appears on the card):	Cardholder Signature:	Date
Billing address	City, State, Zip	Telephone