Pulmonary Test Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

PRIMARY PATIENT

LAST NAME	FIRST NAME		
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown		
MED REC#/PATIENT IDENTIFIER	ETHNICITY		
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	EMAIL		
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Bucal ◯ Other ◯ Extracted DNA & DNA Source: (Blood, Bucal, Tissue, Fibroblast)		

I have read the Informed Consent document and I give permission to Claro Lab to perform genetic testing as described. I also give permission for my specimen and clinical information to be used inde-identified studies at Claro lab and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.Clarolaboratory.com/policies/privacy-policy.

☐ Opt out of research

☐ Check this box if you are a New York state resident and give permission for Claro lab to retain any remaining sample longer than 60 days after the completion of testing.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

ORDER PROVIDER

INSTITUTION/PRACTICE NAME		INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME		PROVIDER FIRST NAME
NPI (USA)	MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)
PROVIDER ADDRESS		
CITY	STATE/PROVINCE	POSTAL CODE / COUNTRY
PROVIDER PHONE	FAX REPORT TO	
GC/PRIMARY CONTACT	GC/PRIMARY CONTACT PHONE/EMAIL/FAX	

I attest that the patient has received and read the Claro Lab Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Claro Lab Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)
X	

INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

PLEASE ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE		REFERRAL/PRIOR AUTH	By signing above, the patient or insured authorizes Claro Lab Genetics to release medical information concerning the test to the assigned insurance company.
PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

INSTITUTION/PRACTICE NAME			
ATTENTION TO			
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	FAX/EMAIL		

SELF PAY

◯ Use patient information above for billing
◯ Use information below for billing

By signing above, the patient or payor authorizes Claro Lab to contact them directly, and use the provided billing instructions to bill the indicated method.

PAYOR LAST NAME	PAYOR FIRST NAME		
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	FAX/EMAIL		

If I am covered by insurance, I authorize CLARO LABS and their contracted billing company to give my insurance carrier the information on this form and provided by my healthcare provider that is necessary for reimbursement. I understand that I am responsible for deductible and coinsurance amounts as indicated by my insurance carrier. I agree to assist in resolving insurance claim issue ans if I do not assist, I may be responsible for the sill cost of the test. I understand that I am responsible for sending CLARO LABS any and all of the money that I receive directly from my insurance carrier in payment for this test.

If the test is not authorized by or is not covered by my insurance, than I will be contacted with the option to either cancel the ordered test or elect to pay out-ofpocket according to the proposed payment plan provided to me when I am contacted. If I elect to pay out-of-pocket, I will be responsible for all payment obligations arising from the ordered testing and guarantee payment for these services. I understand that if payments or arrangements are not made after 3 statements my information may be sent to collections.

Claro Labs is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card. You may also contact our billing team at 518-702-4353.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

Pulmonary Test Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

tesis labs

CLINICAL HISTORY

Attach any available detailed medical records and clinical notes

Clinical Details

Check all that apply:

☐ Mosacism ☐ Bone Marrow Transplant ☐ Known Chromosomal Gain/Loss

☐ Consanguinity ☐ Organ Transplant ☐ Known Gene Gain/Loss

There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high risk ethnicity groups, and transplants. Please list any that may appl y. For additional details, please see the Claro Lab website.

Please specify any that are checked above

Clinical Presentation

Please indicate any clinical presentations and/or findings that may be relevant to genetic testing:

- Behavior
- Conditions
- Pedigree/Family History
- Phenotypes
- Physical
- Symptoms

There are many presentations which may not seem like a direct association for disease. Please list the most suspected presentations and attach detailed medical records and/or pedigree.

Clinical Testing

Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:

- Karyotype
- Previous Genetic Testing
- Vision
- Hearing
- Growth Measurements
- Biochemical Testing
- Imaging
- Pathology Reports

Please also include tests that had a negative result. These tests help our clinical staff process the results of your testing.

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER 1 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 2 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 3 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DOB (MM/DD/YYYY)

TEST REQUESTED – *Select only one test*

◯ **Pulmonary Arterial Hypertension**

AQP1, BMPR2, ENG, ABCC8, ACVRL1, CAV1, EIF2AK4, KCNA5, KCNK3, ALK1, BMPR1B, CBLN2, SMAD9(13 genes)

◯ **Cystic Lung Disease**

SERPINA1, TSC1, TSC2, EFEMP2, ELN, FBLN5, FLCN, LTBP4(8 genes)

◯ **Lung Disorders Comprehensive**

CFTR, SERPINA1, PHOX2B, RET, BMPR2, ENG, SCNN1A, SCNN1B, SCNNIG, TSC1, TSC2, FBN1, NAF1, NF1, ABCA3, ACVRL1, AP3B1, ASCL1, BDNF, BLOC1S3, BLOC1S6, CCDC39, CCDC40, DNAAF1, DNAAF2, DNAH11, DNAH5, DNAI1, DNAI2, DNAL1, DTNBP1, EDN3, EFEMP2, ELN, FBLN5, FLCN, GDNF, HPS1, HPS3, HPS4, HPS5, HPS6, LTBP4, MUC5B, NME8, RSPH4A, RSPH9, SFTPA1, SFTPA2, SFTPB, SFTPC, SMAD9, TERC, TERT(54 genes)

Pulmonary Test Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient informed consent form for genetic testing can be found on Clarolaboratory.com. Signature from the provider on Page 1 of the TRF is required for all testing . Signature from the patient is only required for billing purposes.
3. Write in the test name and indicate any relevant test options. Please call us if you have any questions.
4 . Add-on any additional genes.Visit our website for our most updated list of 18,000+ available genes.
5. For Duo/Trio testing, please complete the Family Samples section or submit a separate TRF for each sample .
6. Please visit Clarolaboratory.com for specimen requirements.

Extracted DNA must extracted from a CL/A-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP an d/or CMS.

INSTRUCTIONS

- ☐ Detailed medical record (pedigree if available)
- ☐ ICD-10 codes(s)
- ☐ Physician, patient, and insured signatures
- ☐ Copy of insurance card(s) - front/back
- ☐ Insurer specific forms (i.e. ABN)
- ☐ Insurance authorization, if available
- ☐ For medicare, medicare criteria form is required

For the most updated information and limitations on our products and services, please visit Clarolaboratory.com