Quest Diagnostics®

# Hereditary Cancer Risk Testing

**BILL TO:**
- ☐ My Account
- ☐ Insurance Provided
- ☐ Lab Card/Select
- ☐ Patient

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SEX

LAB REFERENCE # | CELL PHONE ( )

**PATIENT ID # / MRN** | **PATIENT PHONE** ( )

**PATIENT EMAIL ADDRESS**

**DID YOU KNOW**

**IMPORTANT! THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY.**

**Reflex tests are performed at an additional charge.**

**Each sample should be labeled with at least two patient identifiers at time of collection.**

**ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.**

ACCOUNT #:

NAME:

ADDRESS:
CITY, STATE, ZIP

TELEPHONE #:

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYERS (MUST BE INDICATED)

**PRIMARY INSURANCE**

CITY | STATE | ZIP

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

PRIMARY INSURANCE CO. NAME

MEMBER / INSURED ID NO. # | GROUP #

INSURANCE ADDRESS

CITY | STATE | ZIP

☐ Preauthorization approved Preauthorization number: _____

☐ Preauthorization not submitted

☐ ADDIT'L PHYS.: Dr._____ NPI/UPIN

| NON-PHYSICIAN PROVIDER: | NAME | I.D.# |
|---|---|---|
| | | |

☐ Fax Results to: ( )_____

Send Duplicate Report to:
Client # OR NAME:_____
ADDRESS:_____
CITY:_____ STATE_____ ZIP_____

**ABN required for tests with these symbols**

**Medicare Limited Coverage Tests**
**@** = May not be covered for the reported diagnosis.
**F** = Has prescribed frequency rules for coverage.
**&** = A test or service performed with research/experimental kit.
**B** = Has both diagnosis and frequency-related coverage limitations.

**Provide signed ABN when necessary**

**Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines**

**ICD Codes (enter all that apply)**

FOLD HERE

## THIS REQUISITION MUST BE ACCOMPANIED BY THE COMPLETED PATIENT AND FAMILY CLINICAL HISTORY FORM.

**For fastest processing, please fax this Requisition and Patient and Family Clinical History Form to 855.422.5181. The Clinical History form can also be completed online at YourHistoryForm.com**

**Specimen Source**
- ☐ Blood
- ☐ Saliva
- ☐ Buccal

Other sample types call 1-866-GENEINFO (1-866-436-3463) prior to collecting and ordering

### Breast Cancer Risk

**91863** ☐ **BRCA Panel** - *BRCA1* and *BRCA2*

**92587** ☐ **BRCA Panel Plus (7 Genes)**
*BRCA1, BRCA2, CDH1, PALB2, PTEN, STK11, TP53*

**38621** ☐ **Hereditary Breast Cancer Panel (18 Genes)**
*ATM, BARD1, BRCA1, BRCA2, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53*

**91864** ☐ **BRCA Ashkenazi Jewish Screen**
(Common founder mutations *BRCA1* c.68_69del, *BRCA1* c.5266dup, and *BRCA2* c.5946del)

**92140** ☐ **BRCA Ashkenazi Jewish Screen with Reflex to *BRCA1/2* Sequencing and Deletion/Duplication**
(BRCA Ashkenazi Jewish Screen, if negative reflex to BRCA Panel-*BRCA1* and *BRCA2)*

### Colorectal Cancer/Polyposis Risk

**94053** ☐ **Juvenile Polyposis Panel** - *BMPR1A* and *SMAD4*

**91461** ☐ **Lynch Syndrome Panel** - *MLH1, MSH2* (inc. *EPCAM), MSH6,* and *PMS2*

**38631** ☐ **Hereditary Colorectal Cancer Panel (20 Genes)**
*APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53*

### Expanded Hereditary Cancer Risk Panels

**38611** ☐ **Guideline Based Hereditary Cancer Panel (32 Genes)**
*APC, ATM, AXIN2, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A (p16, p14), CHEK2, EPCAM, GREM1, HOXB13, MLH1, MSH2, MSH3, MSH6, MUTYH, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53*

**38600** ☐ **Comprehensive Hereditary Cancer Panel (66 Genes)**
*APC, ATM, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN1B, CDKN2A (p16, p14), CHEK2, DICER1, EGFR, EPCAM, FANCA, FANCC, FANCM, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MITF, MLH1, MRE11 (MRE11A), MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, POT1, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RECQL, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMARCA4, SMAD4, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2*

### Other Cancer Risk

**38661** ☐ **Tuberous Sclerosis Complex Panel** - *TSC1* and *TSC2*

**38651** ☐ **Nevoid Basal Cell Carcinoma (Gorlin) Syndrome Panel** - *PTCH1* and *SUFU*

**38641** ☐ **Hereditary Endocrine Cancer Panel (12 Genes)**
*FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL*

### Single Gene Tests

**(For a known familial mutation please see single site testing)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 93797 | ☐ *APC* | 38805 | ☐ *FH* | 91458 | ☐ *MSH6* | 38809 | ☐ *SMARCA4* |
| 38802 | ☐ *ATM* | 38806 | ☐ *FLCN* | 93944 | ☐ *MUTYH* | 92565 | ☐ *STK11* |
| 38803 | ☐ *BAP1* | 38807 | ☐ *HOXB13* | 93941 | ☐ *NF1* | 92560 | ☐ *TP53* |
| 38804 | ☐ *BLM* | 93942 | ☐ *MEN1* | 92571 | ☐ *PALB2* | 93943 | ☐ *VHL* |
| 92568 | ☐ *CDH1* | 38808 | ☐ *MITF* | 91457 | ☐ *PMS2* | | |
| 93939 | ☐ *CDKN2A* | 91460 | ☐ *MLH1* | 92566 | ☐ *PTEN* | | |
| 93940 | ☐ *CHEK2* | 91471 | ☐ *MSH2* (inc. *EPCAM*) | 93796 | ☐ *RET* | | |

### Single site testing for any gene in the Comprehensive Hereditary Cancer Panel

**93945** ☐ Gene Name: _____ Variant Name: _____

Copy of family member's report MUST be submitted with order

**REQUIRED SIGNATURES**

**PATIENT ACKNOWLEDGEMENT**

I authorize Quest Diagnostics (Quest) to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance.

SIGNATURE REQUIRED

Patient Signature _____ Date _____

**STATEMENT OF MEDICAL NECESSITY AND INFORMED CONSENT**

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 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.

Ordering provider signature, credentials & date requested (Required by certain payers)

_____ Date _____



If you have questions regarding this order, please call 866.GENE.INFO

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

SMOOTHSEAL®

SPECIMEN KEY ON BACK

Provide signed ABN when necessary

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

All samples to be shipped ambient, unless otherwise specified.

| Specimen Key: | L | = | Lavender top tube |
|---|---|---|---|
| | ♦ | = | See the QuestHereditaryCancer.com Test Selection Guide for the appropriate clinical application of this test. |

**Patients: Minimize your wait time by scheduling an appointment at a convenient Patient Service Center.**

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment or call 1.888.277.8772 or simply download our mobile app. at QuestDiagnostics.com/mobile

Quest Diagnostics®

# Hereditary Cancer Risk Testing

**BILL TO:**
- ☐ My Account
- ☐ Insurance Provided
- ☐ Lab Card/Select
- ☐ Patient

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SEX

LAB REFERENCE # | CELL PHONE ( )

**PATIENT ID # / MRN** | **PATIENT PHONE** ( )

**PATIENT EMAIL ADDRESS**

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

**DID YOU KNOW**

**IMPORTANT! THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY.**

**Reflex tests are performed at an additional charge.**

**Each sample should be labeled with at least two patient identifiers at time of collection.**

**ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.**

ACCOUNT #:

NAME:

ADDRESS:
CITY, STATE, ZIP

TELEPHONE #:

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYERS (MUST BE INDICATED)

☐ ADDIT'L PHYS.: Dr._____ NPI/UPIN

| NON-PHYSICIAN PROVIDER: | NAME | I.D.# |
|---|---|---|
| | | |

☐ Fax Results to: ( )_____

Send Duplicate Report to:
Client # OR NAME:_____
ADDRESS:_____
CITY:_____ STATE_____ ZIP_____

**PRIMARY INSURANCE**

CITY | STATE | ZIP

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

PRIMARY INSURANCE CO. NAME

MEMBER / INSURED ID NO. # | GROUP #

INSURANCE ADDRESS

CITY | STATE | ZIP

☐ Preauthorization approved Preauthorization number:_____

☐ Preauthorization not submitted

**ABN required for tests with these symbols**

**Medicare Limited Coverage Tests**
- **@** = May not be covered for the reported diagnosis.
- **F** = Has prescribed frequency rules for coverage.
- **&** = A test or service performed with research/experimental kit.
- **B** = Has both diagnosis and frequency-related coverage limitations.

**Provide signed ABN when necessary**

**Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines**

**ICD Codes (enter all that apply)**

| | | | | |
|---|---|---|---|---|
| | | | | |

**THIS REQUISITION MUST BE ACCOMPANIED BY THE COMPLETED PATIENT AND FAMILY CLINICAL HISTORY FORM.**

**For fastest processing, please fax this Requisition and Patient and Family Clinical History Form to 855.422.5181. The Clinical History form can also be completed online at YourHistoryForm.com**

**Specimen Source**
- ☐ Blood
- ☐ Saliva
- ☐ Buccal

Other sample types call 1-866-GENEINFO (1-866-436-3463) prior to collecting and ordering

## Breast Cancer Risk

**91863** ☐ **BRCA Panel** - *BRCA1* and *BRCA2*

**92587** ☐ **BRCA Panel Plus (7 Genes)**
*BRCA1, BRCA2, CDH1, PALB2, PTEN, STK11, TP53*

**38621** ☐ **Hereditary Breast Cancer Panel (18 Genes)**
*ATM, BARD1, BRCA1, BRCA2, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53*

**91864** ☐ **BRCA Ashkenazi Jewish Screen**
(Common founder mutations *BRCA1* c.68_69del, *BRCA1* c.5266dup, and *BRCA2* c.5946del)

**92140** ☐ **BRCA Ashkenazi Jewish Screen with Reflex to *BRCA1/2* Sequencing and Deletion/Duplication**
(BRCA Ashkenazi Jewish Screen, if negative reflex to BRCA Panel-*BRCA1* and *BRCA2)*

## Colorectal Cancer/Polyposis Risk

**94053** ☐ **Juvenile Polyposis Panel** - *BMPR1A* and *SMAD4*

**91461** ☐ **Lynch Syndrome Panel** - *MLH1, MSH2* (inc. *EPCAM), MSH6,* and *PMS2*

**38631** ☐ **Hereditary Colorectal Cancer Panel (20 Genes)**
*APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53*

## Expanded Hereditary Cancer Risk Panels

**38611** ☐ **Guideline Based Hereditary Cancer Panel (32 Genes)**
*APC, ATM, AXIN2, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A (p16, p14), CHEK2, EPCAM, GREM1, HOXB13, MLH1, MSH2, MSH3, MSH6, MUTYH, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53*

**38600** ☐ **Comprehensive Hereditary Cancer Panel (66 Genes)**
*APC, ATM, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN1B, CDKN2A (p16, p14), CHEK2, DICER1, EGFR, EPCAM, FANCA, FANCC, FANCM, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MITF, MLH1, MRE11 (MRE11A), MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, POT1, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RECQL, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMARCA4, SMAD4, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2*

## Other Cancer Risk

**38661** ☐ **Tuberous Sclerosis Complex Panel** - *TSC1* and *TSC2*

**38651** ☐ **Nevoid Basal Cell Carcinoma (Gorlin) Syndrome Panel** - *PTCH1* and *SUFU*

**38641** ☐ **Hereditary Endocrine Cancer Panel (12 Genes)**
*FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL*

## Single Gene Tests

**(For a known familial mutation please see single site testing)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 93797 | ☐ *APC* | 38805 | ☐ *FH* | 91458 | ☐ *MSH6* | 38809 | ☐ *SMARCA4* |
| 38802 | ☐ *ATM* | 38806 | ☐ *FLCN* | 93944 | ☐ *MUTYH* | 92565 | ☐ *STK11* |
| 38803 | ☐ *BAP1* | 38807 | ☐ *HOXB13* | 93941 | ☐ *NF1* | 92560 | ☐ *TP53* |
| 38804 | ☐ *BLM* | 93942 | ☐ *MEN1* | 92571 | ☐ *PALB2* | 93943 | ☐ *VHL* |
| 92568 | ☐ *CDH1* | 38808 | ☐ *MITF* | 91457 | ☐ *PMS2* | | |
| 93939 | ☐ *CDKN2A* | 91460 | ☐ *MLH1* | 92566 | ☐ *PTEN* | | |
| 93940 | ☐ *CHEK2* | 91471 | ☐ *MSH2* (inc. *EPCAM*) | 93796 | ☐ *RET* | | |

## Single site testing for any gene in the Comprehensive Hereditary Cancer Panel

**93945** ☐ Gene Name:_____ Variant Name:_____

Copy of family member's report MUST be submitted with order

**REQUIRED SIGNATURES**

**PATIENT ACKNOWLEDGEMENT**

I authorize Quest Diagnostics (Quest) to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance.

SIGNATURE REQUIRED

Patient Signature _____ Date _____

**STATEMENT OF MEDICAL NECESSITY AND INFORMED CONSENT**

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 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.

Ordering provider signature, credentials & date requested (Required by certain payers)

_____ Date _____



If you have questions regarding this order, please call 866.GENE.INFO

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

SPECIMEN KEY ON BACK

Provide signed ABN when necessary

FOLD HERE

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

All samples to be shipped ambient, unless otherwise specified.

| Specimen Key: | L | = | Lavender top tube |
|---|---|---|---|
| | ♦ | = | See the QuestHereditaryCancer.com Test Selection Guide for the appropriate clinical application of this test. |

**Patients: Minimize your wait time by scheduling an appointment at a convenient Patient Service Center.**

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment or call 1.888.277.8772 or simply download our mobile app. at QuestDiagnostics.com/mobile