

# Georgia Esoteric and Molecular Diagnostic Laboratories, LLC

## Medical College of Georgia

1120 15<sup>th</sup> street, BF-207, Augusta, GA 30912

Tel: (706) 721-5116 Fax: (706) 721-5117

For GEM Labs USE only:

Date Received: \_\_\_\_\_

Sample Type: \_\_\_\_\_

Other: \_\_\_\_\_

### PATIENT INFORMATION

Name (Last, First, MI) \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

SS #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Sex:  Male  Female Pregnant: Y / N

Ethnicity:  Caucasian  Ashkenazi Jewish  African American  Asian  Hispanic  Other \_\_\_\_\_

### REFERRING PHYSICIAN/INSTITUTION

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital/Institution: \_\_\_\_\_

Fax: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Name & Phone of person completing requisition: \_\_\_\_\_ Sign: \_\_\_\_\_

### BILLING INFORMATION

*\*Please complete all the information asked in this section, the referring physician or referring institution would be billed if needed information were incomplete.*

Bill:  Patient  Insurance  Referring Institution  Check/Money Order enclosed for \$ \_\_\_\_\_

Relation:  Spouse  Self  Dependant

ICD9 Codes: *\*Please provide all diagnosis codes applicable for tests medically necessary for that diagnosis and treatment of patient:*

*Please fill out any of the selected option describe below:*

**Credit Card Information:**

Name (as appears on Card): \_\_\_\_\_

Account #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Referring Institution or Physician:**

Name: \_\_\_\_\_

Account #: \_\_\_\_\_

Hospital/Institution: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Insurance/Medicare/Medicaid Information:** *\*Please provide a copy of the front and back of the patient's insurance card (Required)*

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Authorization #: \_\_\_\_\_ Gender:  M  F

Insurance Name: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Group Plan # \_\_\_\_\_ Policy ID # \_\_\_\_\_ Medicare or Medicaid ID # \_\_\_\_\_

*I authorize any holder of medical information about me to release to any insurance carrier any information needed for this claim. I permit a copy of this authorization to be used in place of the original and request that the payment of medical insurance is paid to Georgia Esoteric and molecular Diagnostic Labs LLC. I also understand that I will be held responsible for any portion of the claim that the insurance company does not pay.*

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

### SAMPLE INFORMATION

EDTA Blood  Urine  Paraffin Section

Collection Date: \_\_\_\_\_

Na Heparin Blood  Tissue  Other

Sample Stored at: \_\_\_\_\_

### MOLECULAR CYTOGENETICS TESTS

Indication of Tests \_\_\_\_\_

HER-2/*neu* Gene Amplification (FISH) (2071)

EGFR Gene Amplification (FISH) (2051)

UroVysion for Bladder Cancer (FISH) (2211)

Microarray CGH (2131)

PTEN (FISH) (2161)

ASA Mutation (PCR) (2011)

1p36/1q25 (FISH) (2162)

19p13/19q13 (FISH) (2171)

DNA Extraction (2041)