LSU Health SHREVEPORT | Feist-Weiller Cancer Center
Center for Precision Medicine
Genomics Laboratory
318-813-1438 Business Office/Precertification
318-675-8330 LAB

# FWCC PrecisionSeq500

## GENOMIC TEST REQUISITION FORM

Please complete and fax to 318-813-1009

CLIA # 19D2129256
CAP # 8344013

For BUSINESS OFFICE Use Only

**SAMPLE ID#** For LAB Use Only

MRN# ______________________

Order Date ______________________

**All fields are required. Incomplete orders cannot be processed.**

### PATIENT INFORMATION

Name ______________________

Address ______________________

City ______________________ State ______

Zip Code ______________ Phone # ______________

SSN ______________________ DOB ______________

❍ Male ❍ Female Ethnicity ______________

### PATIENT INSURANCE *Please include legible photocopy of insurance card, front and back.*

❍ Private Insurance ❍ Hospital/Institution

❍ Medicare ❍ Medicaid ❍ Self Pay

Primary Insurance ______________________

Policy # ______________________

Group # ______________________

Insured Name ______________________

Insured DOB ______________________

Relationship to Insured:

❍ Self ❍ Spouse ❍ Child ❍ Other

Insurance Phone # ______________________

### ORDERING PHYSICIAN

Ordering Physician ______________________

NPI# ______________________

Practice/Institution ______________________

Address ______________________

City ______________________

State ______________ Zip Code ______________

Office Contact ______________________

Phone # ______________ Fax # ______________

Email ______________________

I certify that the requested test is medically necessary and that I have obtained informed consent to permit FWCC Genomics Laboratory to (a) perform the specified testing, (b) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (c) release the test results to the patient's third-party payor for reimbursement purposes.

X ______________________

Ordering Physician's Signature Date ______________

### TEST ORDERED

● **PrecisionSeq500**

○ **URGENT: results required within 2 weeks of sample receipt**
**Please state reason for request** ______________
______________________

○ **Loxo/Lilly Underserved Population study: enrolled**

○ **PDL1-IHC**

***Medical Necessity- please attach clinic noteS***

### DIAGNOSIS (*Must be complete for prior authorization.*)

Diagnosis ______________________

Stage ______________________

Primary Tumor Site ______________________

ICD-10 Codes ______________________

### PATHOLOGY/SPECIMEN

*(Please attach a copy of the pathology report, if available.)*

Hospital/Institution ______________________

Phone Number ______________________

Fax Number ______________________

Specimen ID ______________________

Specimen Site ______________________

❍ Primary ❍ Metastatic

Date Collected ______________________

### CHECK LIST

❍ Patient Information (MRN#)

❍ Specimen Information/ ID

❍ Patient Insurance

❍ Diagnosis

❍ Copy of Pathology Report

❍ Ordering Physician Information

❍ Ordering Physician Signature

❍ Clinic Note/Explanation of Medical Necessity