IMMUCOR | DX
Reference Laboratory
CLIA# 23D1054909 CAP#7195469

Place Label Here

1-800-363-5915
Fax: 616-284-3738
Mon—Fri 8a-4p EST
301 Michigan Street NE Suite #572
Grand Rapids, MI 49503
www.Immucor.com/DX
ImmucorDX@Immucor.com

TEST REQUISITION - HEA, HPA, RHCE, RHD

PATIENT INFORMATION AND ACKNOWLEDGEMENT

Last name: _____ First name: _____ DOB: _____ / _____ / _____

Sex: _____ MRN: _____ Street address: _____

City: _____ State: _____ Zip: _____

HEA is an FDA approved test. For all other tests listed, the performance characteristics of the test were validated by Immucor DX Laboratories, which is authorized under Clinical Laboratory Improvement Amendments (CLIA) to perform high-complexity testing. The results are not intended to be used as the sole means for clinical diagnosis or patient management decisions. My signature below constitutes my acknowledgement that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional. The results of my testing are confidential and will only be released to the ordering healthcare provider. Release of results to the other medical professionals or directly to me (the patient) must be requested by me in writing. My sample may be stored indefinitely to be used for test validation, education, or research after personal identifiers are removed. I may request disposal of my sample following completion of the test requested above by contacting the laboratory at 800-363-5915.

If insurance bill, I represent that I am covered by insurance and authorize Immucor DX (Herein referred to as "the Lab") to give my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the information on this form and other information provided by my healthcare provider necessary for reimbursement. I authorize the Lab to inform my Plan of my test result only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to the Lab. I will cooperate fully with the Lab by providing all necessary documents needed for insurance billing and appeals. I authorize the Lab to appeal on my behalf. I understand that I am responsible for sending the Lab any and all of the money that I receive directly from my insurance company in payment for this test. I understand that I am financially responsible for any non-covered services, co-payments, deductibles or co-insurance balances as indicated by my insurer. Reasonable collection and/or attorney's fees, including filing and service fees, shall be assessed if the account is sent to collection but said fees shall not exceed those permitted by state law. I permit a copy of this authorization to be used in place of the original.

Patient's Signature: _____ Date: _____/_____/_____

(Patient signature not required if Client Bill)

TEST MENU Check all that apply, a box MUST be checked in order to perform testing

- ☐ **HEA** (Human Erythrocyte Antigens) PLA/CPT: 0001U/81403
- ☐ **HPA** (Human Platelet Antigens) 81400
- ☐ **RHCE** Genotyping 81403
- ☐ **RHD** Genotyping 81403

☐ **STAT** (72 hours/ 3 business days) Additional fees will apply

SAMPLE COLLECTION AND TYPE (select one and provide details)

Date Collected: Time Collected:

Collected By (Full Name):

☐ Blood (EDTA) # of tubes: _____

☐ Buccal (Isohelix Dri-Capsule)

☐ DNA DNA Concentration: _____ (ng/µl)

DNA must have been extracted in a CLIA certified laboratory or laboratory meeting equivalent requirements as determined by CAP and/or CMS

BILLING INFORMATION Attach copies of both sides of insurance card

□ Client Billing □ Patient Billing □ Insurance Billing	If insurance bill: Relation: □ Self □ Spouse □ Dependent	Immucor DX Account #: PO #:

Insurance Carrier:

Insured's Name (if not patient):

Insured's DOB:

Claims/Billing Address:

City/State/Zip:

Policy #: Group #:

Authorization #:

CODING GUIDE

- ☐ **C90.00** Multiple Myeloma not having achieved remission
- ☐ **D53.9** Nutritional anemia, unspecified
- ☐ **D56.1** Beta thalassemia
- ☐ **D56.9** Thalassemia, unspecified
- ☐ **D57.1** Sickle-cell disease without crisis
- ☐ **D57.219** Sickle-cell/Hb-C disease with crisis, unspecified
- ☐ **D57.40** Sickle-cell thalassemia without crisis
- ☐ **D57.80** Other sickle-cell disorders without crisis
- ☐ **D58.9** Hereditary hemolytic anemia, unspecified
- ☐ **D60.0** Chronic acquired pure red cell aplasia
- ☐ **D63.0** Anemia in neoplastic disease
- ☐ **D64.89** Other specified anemias
- ☐ **D69.51** Post Transfusion Purpura
- ☐ **O36.829** Fetal Anemia, unspecified trimester
- ☐ **P61.0** Transient Neonatal Thrombocytopenia
- ☐ **C90.02** Multiple Myeloma in relapse
- ☐ **D56.0** Alpha thalassemia
- ☐ **D56.3** Thalassemia minor
- ☐ **D57.00** Hb-SS disease with crisis unspecified
- ☐ **D57.20** Sickle-cell/Hb-C disease without crisis
- ☐ **D57.3** Sickle-cell trait
- ☐ **D57.419** Sickle-cell thalassemia with crisis, unspecified
- ☐ **D57.819** Other sickle-cell disorders with crisis, unspecified
- ☐ **D59.9** Acquired hemolytic anemia, Unspecified
- ☐ **D61.1** Drug-induced aplastic anemia
- ☐ **D63.1** Anemia in chronic kidney disease
- ☐ **D69.3** Immune Thrombocytopenic Purpura
- ☐ **O09.9** Supervision of High Risk Pregnancy, unspecified
- ☐ **Z34.9** Supervision of Normal Pregnancy, unspecified

☐ **Other ICD-10 Codes or Risk Factors :** _____

For the latest list of ICD-10 codes please visit: www.cms.gov

PROVIDER/CLIENT INFORMATION

Ordering Provider:

NPI# (Provider Only):

Submitting Client:

Tel: Fax:

Address:

City: State: Zip:

Copy to Provider:

NPI#:

Tel: Fax:

INFORMED CONSENT AND STATEMENT OF MEDICAL NECCESSITY

I confirm that the person listed as the Ordering Clinician/Client is authorized by law to order the test(s) requested herein. The patient has been informed that the test requested is a genetic test and supplied information regarding genetic testing. The patient has given consent for genetic testing to be performed and for their sample to be stored indefinitely to be used for test validation, education, or research after personal identifiers are removed. I further confirm that this test is medically necessary and the results will be used in the medical management and treatment decisions for the patient. I acknowledge that any results provided by Immucor DX are confidential and agree that I shall not disclose any such results to any unauthorized person or entity. I understand that the ordering institution is financially responsible for any client bill fees invoiced by Immucor.

Provider/Client Signature: _____ Date: _____