



Attn: CLIA Laboratory  
 2150 Woodward St., Suite 100  
 Austin, TX 78744, USA  
 Phone #: (877) 772-8018  
 Fax #: (512) 681-5202  
 www.asuragen.com  
 ClinicalLabSupport@Asuragen.com



### 1 | SUBMITTING PHYSICIAN ACCOUNT INFORMATION

Physician Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Fax #: \_\_\_\_\_  
 Physician/NPI #: \_\_\_\_\_  
 Account #: \_\_\_\_\_  
 Results delivery:  email  fax  mail

### 2 | PATIENT INFORMATION

Patient's Face Sheet attached to the Test Requisition

Name: \_\_\_\_\_  
Last First Middle Initial

DOB: \_\_\_\_\_ Sex:  MALE  FEMALE  
(MM/DD/YYYY)

Street Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ MR # or SSN: \_\_\_\_\_

### 3 | TEST MENU

1.  Xpansion Interpreter\*

### 4 | SPECIMEN INFORMATION - MATERIALS SHIPPED

Date of Sample Collection: \_\_\_\_\_  
 Date Sent to Asuragen Clinical Laboratory: \_\_\_\_\_  
 Sample Type:  Whole Blood (EDTA/Purple top)  Extracted DNA (350ng minimum)  
*See Sample Collection Instructions*  
 If extracted, please list original sample type \_\_\_\_\_

### 5 | BILLING INFORMATION

As a courtesy we will bill your insurance. We do not accept Medicaid. Please attach a copy (front and back) of insurance card (s); complete billing information must be provided below.  
 NOTE: If patient is a minor, parent or guardian information is required.

Patient's Face Sheet attached to the Test Requisition

Insurance carrier: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group name: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_  
 Policy holder phone #: \_\_\_\_\_  
 Policy holder DOB: \_\_\_\_\_  
(MM/DD/YYYY)  
 Relation to patient: \_\_\_\_\_  
 Bill to:  Insurance  Patient  Medicare  Laboratory Account

**SECONDARY INSURANCE:** As a courtesy you may also submit secondary insurance information. Please attach a copy (front and back) of your secondary insurance. You must also provide the following information: secondary insurance carrier, policy #, group name and group #, billing address and phone #, policy holder name, ID #, DOB, relation to patient and phone #.

### 6 | DIAGNOSIS (REQUIRED INFORMATION)

Clinical diagnosis: \_\_\_\_\_  
 ICD9 Codes: \_\_\_\_\_  
 Pertinent patient clinical and family history: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 7 | ORDERING PHYSICIAN'S SIGNATURE

*I hereby certify that the request for the above test for which reimbursement from Medicare, or third party payors, will be sought by Asuragen is reasonable and medically necessary for the diagnosis, care and treatment of this patient's condition. I also authorize Asuragen to send on my behalf this patient's test results to the patient's third party payor. I certify that I have obtained informed consent in writing from the patient or their legal guardian that includes: a description of the test and the condition tested for; a statement that prior to signing the consent form, the patient or legal guardian discussed the benefits, risks, and limitations of genetic testing for Fragile X and associated disorders with me; that genetic counseling is available and who the consenting person may contact for such counseling; and the persons to whom the test results may be disclosed.*

Signature	Print name	Order date
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\*Laboratory developed tests are not yet FDA reviewed.