



# GTC Requisition User Guide

Please follow the below instructions to complete the Genomic Testing Cooperative requisition form.

## 1. Client Information

Account Number:  
Account Name:

## 2. Patient Information

**Patient Legal Name** (Last, First, MI), Gender, DOB, AND Medical Record number  
Requisition Completed by: Signature and Date  
**Ordering Physician:** Name (Last, First), NPI #  
Treating Physician: Name (Last, First), NPI #  
**Test Authorization and Physician Signature:** Required information to support medical necessity for the patient's condition.

## 3. Billing Information for Orders by Clients/ Non-Members

**Complete Specimen Origin:** Please choose one option  
**Bill to:** Please specify Client or Insurance billing and include complete patient insurance information to prevent delay in testing

**Client Bill:** All charges will be billed to Client  
**Insurance/Medicare/Medicaid:** All charges billed to insurance except when payer follows CMS guidelines and patient status indicated as inpatient  
**Patient/self-pay:** All charges billed to patient  
**Bill charges to other Hospital/Facility:** If alternate facility other than listed in above Client information is please indicate name, phone and address here.

**ICD diagnosis code:** Required information for medical necessity and billing

## 4. Diagnosis/Patient History

**Solid Tumors:** Specify type and stage of tumor and please include the most recent copy of pathology report  
**Hematologic Tumors:** Specify type and please include a copy of most recent pathology report and CBC results

## ITEMS IN RED ARE REQUIRED TO PERFORM THE TESTING

The screenshot shows the 'TEST REQUISITION' form with several fields circled in red and numbered 1 through 6. The form is divided into sections: Client Information, Patient Information, Billing Information for Orders by Non-Members, Diagnosis/Patient History, and Test Selection. The red circles highlight the following fields: 1. Account #; 2. Patient Name (Last, First, MI) and Gender (Male/Female); 3. Billing Information (Client Bill, Insurance, Medicare/Medicaid, or Other Hospital/Facility); 4. Specimen Origin (Hospital Patient, Non-Hospital Patient); 5. Specimen Information (Collection Date, Specimen ID/Block ID, Hospital Discharge Date, Body Site, and Fixative/Preservative); 6. Test Selection (Solid Tumors Tests and Hematologic Tumors Tests).

## 5. Specimen Information

Please include specimen detail of the sample you are submitting, include **collection date, specimen ID and specimen type**

## 6. Test Selection

Specify solid tumor or hematologic **test requested** to be performed on patient sample.

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