

# 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.

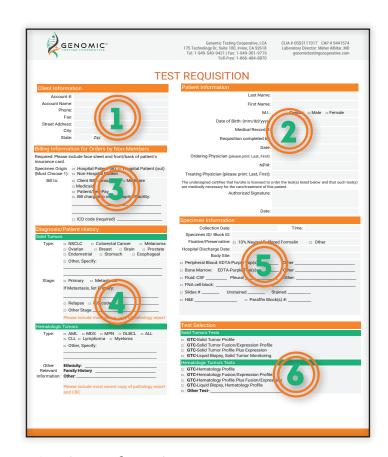
**ICD diagnosis code:** Required information for medical necessity and billing

## 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



### 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.

# ITEMS IN RED ARE REQUIRED TO PERFORM THE TESTING

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