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

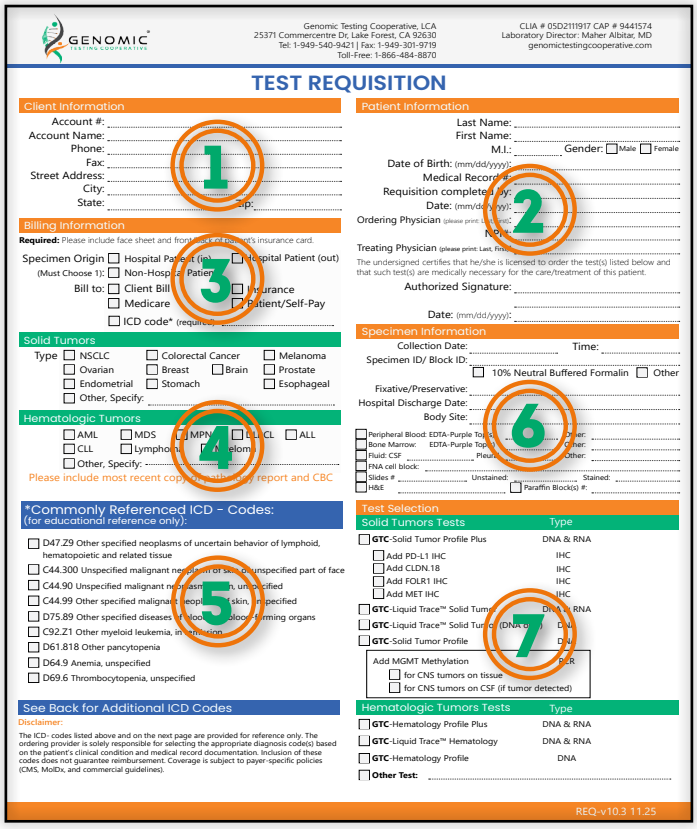
4.Diagnosis/Patient History

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

5. ICD Diagnosis Code(s)

Select the appropriate **ICD diagnosis code(s)** for the patient. This field is required and is important for medical necessity and reimbursement processing.

ITEMS IN RED ARE REQUIRED TO PERFORM THE TESTING


GENOMIC TESTING COOPERATIVE
Genomic Testing Cooperative, LCA
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Tel: 1-949-540-9421 | Fax: 1-949-301-9719
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CLIA # 05D2111917 CAP # 9441574
Laboratory Director: Maher Albitar, MD
genomictestingcooperative.com

TEST REQUISITION

Client Information
Account #:
Account Name:
Phone:
Fax:
Street Address:
City:
State:
Zip:

Patient Information
Last Name:
First Name:
M.I.:
Gender: Male Female
Date of Birth: (mm/dd/yyyy):
Medical Record #:
Requisition completed by:
Date: (mm/dd/yyyy):
Ordering Physician (please print: Last, First):
NPI #:
Treating Physician (please print: Last, First):
The undersigned certifies that he/she is licensed to order the test(s) listed below and that such test(s) are medically necessary for the care/treatment of this patient.
Authorized Signature:
Date: (mm/dd/yyyy):

Billing Information
Required: Please include face sheet and front/back of patient's insurance card.
Specimen Origin (Must Choose 1): Hospital Patient (in) Hospital Patient (out) Non-Hospital Patient
Bill to: Client Bill Insurance Medicare Patient/Self-Pay
ICD code* (required)

Solid Tumors
Type NSCLC Colorectal Cancer Melanoma Ovarian Breast Brain Prostate Endometrial Stomach Esophageal Other, Specify:

Hematologic Tumors
AML MDS MPN DLBCL ALL CLL Lymphoma Myeloma Other, Specify:
Please include most recent copy of pathology report and CBC

Specimen Information
Collection Date: Time:
Specimen ID/ Block ID:
10% Neutral Buffered Formalin Other
Fixative/Preservative:
Hospital Discharge Date:
Body Site:
Peripheral Blood: EDTA-Purple Top Other:
Bone Marrow: EDTA-Purple Top Other:
Fluid: CSF Pleural Other:
FNA cell block:
Slides # Unstained: Stained:
H&E Paraffin Block(s) #:

*Commonly Referenced ICD - Codes: (for educational reference only):
D47.Z9 Other specified neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue
C44.300 Unspecified malignant neoplasm of skin of unspecified part of face
C44.90 Unspecified malignant neoplasm of skin, unspecified
C44.99 Other specified malignant neoplasm of skin, unspecified
D75.89 Other specified diseases of blood and blood-forming organs
C92.Z1 Other myeloid leukemia, in remission
D61.818 Other pancytopenia
D64.9 Anemia, unspecified
D69.6 Thrombocytopenia, unspecified

See Back for Additional ICD Codes
Disclaimer:
The ICD- codes listed above and on the next page are provided for reference only. The ordering provider is solely responsible for selecting the appropriate diagnosis code(s) based on the patient's clinical condition and medical record documentation. Inclusion of these codes does not guarantee reimbursement. Coverage is subject to payer-specific policies (CMS, MolDx, and commercial guidelines).

Test Selection
Solid Tumors Tests — Type
GTC-Solid Tumor Profile Plus — DNA & RNA
Add PD-L1 IHC — IHC
Add CLDN.18 — IHC
Add FOLR1 IHC — IHC
Add MET IHC — IHC
GTC-Liquid Trace™ Solid Tumor — DNA & RNA
GTC-Liquid Trace™ Solid Tumor (DNA only) — DNA
GTC-Solid Tumor Profile — DNA
Add MGMT Methylation — PCR
for CNS tumors on tissue
for CNS tumors on CSF (if tumor detected)

Hematologic Tumors Tests — Type
GTC-Hematology Profile Plus — DNA & RNA
GTC-Liquid Trace™ Hematology — DNA & RNA
GTC-Hematology Profile — DNA
Other Test:

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Please also review the additional ICD codes listed on the back page and select the code(s) that best match the patient's clinical condition.

6.Specimen Information

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

7.Test Selection

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

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