Devyser Laboratory

Test Requisition Form

1. Patient information

First Name: _____ **Last Name:** _____ **DOB (MM/DD/YYYY):** _____

MRN/Patient ID: _____ **Collection Date (MM/DD/YYY):** _____ **SAB:** ☐ Male ☐ Female

Maternal Weight: _____ **Maternal Height:** _____

Phone: _____ **Street Address:** _____ **Apt/Unit/Suite:** _____

City: _____ **State:** _____ **Zip code:** _____

Race: ☐ White ☐ Black ☐ Asian/Pacific ☐ Hispanic ☐ North American Native ☐ Other

2. Provider/Client Information

Facility name: _____ **Account # (SAP):** _____

Address: _____ **Address #2/Facility Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Qualified Healthcare Provider: _____

Phone: _____ **Fax:** _____ **Email:** _____

Treatment Provider: _____

Phone: _____ **Fax:** _____ **Email:** _____

Provider Authorization

This requisition constitutes an order for molecular testing from **Devyser Laboratory**. I certify (a) the services are medically necessary and will assist me in treating my patient, (b) I maintain and will make available patient medical records documenting the foregoing, (c) I have supplied information to the patient regarding this testing and the patient has consented to genetic testing. Regarding patient consent, the ordering physician will be solely responsible for confirming that legally effective informed consent has been obtained from the patient or his/her authorized representative as required by applicable state law. By ordering a test from **Devyser Laboratory** the physician certifies that this consent is in place and that test results will be used and disclosed only in accordance with applicable law. I have signed statements on file from the patient and in accordance with your practice or institution permitting you and your contracted vendors to release data to other organizations to adjudicate claims.

First Name: _____ **Last Name:** _____ **Provider 10-Digit NPI #:** _____

Provider Signature: _____ **Date (MM/DD/YYYY):** _____

3. Select Test

☐ **Fetal RhD for RhD negative mothers**

4. Clinical Indications

Pregnant: Yes ☐ No ☐

Estimated Due Date (MM/DD/YYYY): _____ **Pregnancy Details (If applicable):** Twins ☐ Triplets or Higher ☐

ICD-10 Codes: ☐ Z31.82 Encounter for Rh incompatibility status ☐ Other: _____

5. Billing/Insurance Information

☐ Client/Institution Billing ☐ Inpatient ☐ <14 Days after discharge

☐ Commercial Billing ☐ Outpatient ☐ Non-Patient ☐ >14 Days after discharge

Attach copy of front & back of insurance card or face sheet ☐ Medicare/Advantage ☐ Private Insurance ☐ Medicaid

Insurance Co. Name: _____ **Member ID:** _____ **Group ID:** _____

Relation: ☐ Self ☐ Spouse ☐ Dependent ☐ Other: _____

Policy Holder Name: _____ **Policy Holder DOB (MM/DD/YYYY):** _____

Dvysr®

Devyser
11660 Alpharetta Highway,
Suite 700, Office 770
Roswell, GA 30076

CLIA ID: 11D2278668

www.devyser.com/our-laboratory

Devyser Laboratory

Test Requisition Form

Specimen

Whole Blood

Volume/Amount

> 6mL

Container

EDTA collection tube

Additional information

Samples can be stored refrigerated (2 to 8°C).
Do not freeze. Samples must be received
within 6 days after collection.

Before you ship, please make sure that

1. **Test Panel and ICD-10 codes** are selected
2. **Required fields** on this form are complete
3. **Insurance card copies** are included
4. Requisition is **signed.**

Shipping Address

Devyser Labs
11660 Alpharetta Highway
Suite 700 Office 770
Roswell, GA 30076

Contact Information

Kelly.VanBemmel@us.devyser.com