# Devyser Genomic Laboratories

## 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 Genomic Laboratories**. 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 Genomic Laboratories** 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 Genomic Laboratories**
11660 Alpharetta Highway,
Suite 700, Office 770
Roswell, GA 30076

**CLIA ID:** 11D2278668

**www.devyser.com/our-laboratory**

# Devyser Genomic Laboratories

## 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 Genomic Laboratories
11660 Alpharetta Highway
Suite 700 Office 770
Roswell, GA 30076

### Contact Information
clientservices@us.devyser.com