



# HEARING LOSS TEST REQUISITION FORM (page 2)

Other relatives with hearing loss? Yes _____ No _____  If Yes, please specify relationship to patient: _____  Inheritance: ___recessive ___dominant ___X-linked  ___Mitochondrial	<b>PEDIGREE OR SUMMARY OF FAMILY HISTORY</b>
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## REFERRING PHYSICIAN/GENETIC COUNSELOR INFORMATION

Physician Name ( print): \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Genetic Counselor Name( print): \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
\_\_\_\_\_

REFERRING PHYSICIAN SIGNATURE (REQUIRED)

DATE

## BILLING INFORMATION (complete or attach)

(CHOOSE ONE METHOD OF PAYMENT)

1.  Check enclosed  Money Order  Credit Card (AMEX / MC / VISA / DISCOVER - Please Circle One)

Account #: \_\_\_\_\_ Exp date: \_\_\_\_\_  
Cardholder name (print): \_\_\_\_\_  
Cardholder signature: \_\_\_\_\_

2.  Referring Institution or MD

Institution Name: \_\_\_\_\_ Financial Contact: \_\_\_\_\_  
Billing Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_ Fax #: \_\_\_\_\_  
Email (required): \_\_\_\_\_

3.  Insurance/Policyholder's Information

▪ HMO, PPO, Commercial Ins - provide front/back copy of insurance card.

▪ OH, IN, KY - all other states' Medicaid require letter of authorization

Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_-\_\_\_-\_\_\_ Gender: M / F  
Authorization #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_

Check here if patient signed completed ABN

Medical Necessity Regulations: At the government's request, the Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

**\*\*ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED\*\***