

Lawrence M. Weiss, MD  
 Laboratory Director, CLIA #05D0665695  
 Juan-Sebastian Saldivar, MD, FACMG  
 Director of Molecular Diagnostics

**Molecular Diagnostic Laboratory**  
 1500 East Duarte Road  
 Northwest Building, Second Floor, Room 2236  
 Duarte, CA 91010-3000  
 Phone 888-826-4362 Fax 626-301-8142  
 mdl@coh.org http://mdl.cityofhope.org

For laboratory use only	Kindred #:	Accession #:
-------------------------	------------	--------------

**Note: \* are required fields.**

Patient Information						
Last Name*	First Name*	Middle Initial	Social Security #	Female*	Male*	Date of Birth*
Bond	James			<input type="radio"/>	<input checked="" type="radio"/>	11/11/1920
Street Address*	City*	State (or Country if not USA)*		Zip*	Phone Number*	
777 Bonder ave	Duarte	CA		91010	(626)007-0007	
Specimen Number or Code	Specimen Type	Specimen Amount	Date Collected	Specimen Comments		
Mother's Country or Region of Origin			Father's Country or Region of Origin			
Ethnicity				Other Ethnicity		
Comments (note any consanguinity)				Marital Status*: Single Married Divorced Separated Widowed		
				<input type="radio"/> <input checked="" type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>		

Clinical Findings and Family History (please attach pedigree)
ICD9 Codes (required for insurance)*: 424.0,718.89,V21.0
Diagnosis / Clinical Findings / Family History (please attach pedigree)

Referring Physician and Genetic Counselor (or other contact) Information			
Referring Physician Name*	Referring Physician UPIN	Genetic Counselor (or other contact) Name and Title*	
Ian Fleming		Kissy Suzuki, Genetic Counselor	
Referring Physician Phone*	Physician Institution and Address	Counselor/Contact Phone*	Contact Institution and Address
(626)700-7000		(626)009-0009	
Referring Physician Fax*		Counselor/Contact Fax*	
(626)777-7777		(626)008-0008	
Referring Physician Email*		Counselor/Contact Email*	
IanF@gmail.com		KissyS@hotmail.com	

\* Copy of results will be sent electronically via our secure system; email address also required for status updates.

Tests Ordered (please select tests, one test per line)
FBN1-SEQ (FBN1 gene, full gene sequencing, 4 wks) 83890, 83898 (X67), 83894, 83904 (X67), 83912
PLEASE SELECT A TEST FROM THE DROP-DOWN LIST OR CHECK IT IN AN ATTACHED TEST LISTING - DO NOT WRITE IN THE TEST
PLEASE SELECT A TEST FROM THE DROP-DOWN LIST OR CHECK IT IN AN ATTACHED TEST LISTING - DO NOT WRITE IN THE TEST
PLEASE SELECT A TEST FROM THE DROP-DOWN LIST OR CHECK IT IN AN ATTACHED TEST LISTING - DO NOT WRITE IN THE TEST
PLEASE SELECT A TEST FROM THE DROP-DOWN LIST OR CHECK IT IN AN ATTACHED TEST LISTING - DO NOT WRITE IN THE TEST
<b>**NOTE: MULTIPLE TESTS ARE DONE SIMULTANEOUSLY UNLESS THE ORDER FOR REFLEXIVE TESTING IS NOTED HERE:</b>
Comments on Tests Ordered (gene name for dosage analyses, description of custom test, etc.)

As the referring physician named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, has been offered genetic counseling as appropriate, and has satisfied the informed consent requirements of my institution.

<i>Ian Fleming</i>	
Referring Physician Signature* (required)	Date

## Billing Information

(complete information is required before processing can begin)

**Note: \* are required fields.**

<input checked="" type="radio"/> <b>Bill Insurance (attaching a letter of medical necessity is necessary)</b>			
<b>Name of Primary Subscriber*</b>	Insured Social Security #	<b>Subscriber's Date of Birth*</b>	<b>Relationship to Patient*</b>
Andrew Bond		11/11/1895	Father
<b>Insurance Company Name*</b>	Insurance Company Address	Medicare Number	Medi-Cal Number
Blue Cross/Blue Shield			
<b>Ins Company Customer Service Phone #*</b>		<b>Insurance Group Number*</b>	<b>Insurance Policy Number*</b>
1-877-576-6440		99999999	XXX9999999999
<b>Authorization # (If an HMO policy, specific authorization for City of Hope Medical Center and Medical Group is required.)*</b>			
07777770		<b>Effective Auth Dates*</b>	6/12/08 - 12/12/08

<b>Secondary Insurance</b>			
Name of Insurance Policy Holder	Insured Social Security #	Insured Date of Birth	Relationship to Patient
Insurance Company Name	Insurance Company Address	Medicare Number	Medi-Cal Number
Insurance Company Phone		Insurance Group Number	Insurance Policy Number
<b>Authorization # (If an HMO policy, specific authorization for City of Hope MDL is required.)</b>			

<input type="radio"/> <b>Payment Enclosed (please make check to "City of Hope MDL" and write SSN on check)</b>
--

<input type="radio"/> <b>Charge to Credit Card</b>				
<input type="radio"/> MasterCard <input type="radio"/> VISA <input type="radio"/> Discover <input type="radio"/> American Express	For a receipt, enter name and address:			
Card Holder Full Name	Account Number	Expiration Date	US Dollar Amount	
Card Holder Signature				

<input type="radio"/> <b>Bill to Referring Institution</b>		
Institution Name	Institution Billing Address	
Contact Name	Contact Phone	
<b>Contact Email for Copy of Results*</b>	Fax Number	
KissyS@hotmail.com		

\*Copy of results will be sent electronically via our secure email system.

Billing Notes
---------------

## Front of subscriber's insurance card

 <b>BlueCross® BlueShield®</b> of Kansas City An Independent Licensee of the Blue Cross Blue Shield Association		<i>Preferred-Care Blue</i> <a href="http://www.bcbskc.com">www.bcbskc.com</a>
<b>HOSPITAL ADMISSIONS REQUIRE PRIOR APPROVAL</b>		
<b>James Bond</b>		
<b>ABC999999999 99</b>		
<b>GROUP: 272550000001</b>		<b>75.00 EMER ROOM</b> <b>20.00 OFFICE VISIT</b>
<b>BCBSKC RX</b>	<b>1-800-228-1436</b>	<i>Preferred-Care</i>
<b>BC PLAN: 240 BS PLAN: 740</b>		
<b>CUST SERV: 816-232-8396/800-822-2583</b>		

## Back of subscriber's insurance card

To prior authorize all medical or surgical admissions  
or for Utilization Management review, call:  
816-395-3989 or Toll Free 800-892-6116

If prior approval for a hospital admission is not obtained, the  
claim may not be paid. In the event of an emergency admission,  
Blue Cross and Blue Shield of Kansas City must be notified  
within 48 hours.

For Psychiatric and Substance Abuse Services, call:  
New Directions 913-982-8400 or Toll Free 800-528-5763

To locate a participating PPO provider outside the Blue Cross  
and Blue Shield of Kansas City area, call 800-810-BLUE or  
visit [www.bcbs.com](http://www.bcbs.com).

Health Care Providers must file claims with the LOCAL Blue  
Cross and Blue Shield Plan. All other claims must be sent to:  
Blue Cross and Blue Shield of Kansas City  
PO Box 419169, Kansas City MO 64141-6169

PBDG