City of Hope LABORATORIES
Patricia Aoun, MD, MPH
CLIA Laboratory Director, Department of Pathology, CLIA #05D0665695
Tax ID:95-1683875

Laboratory Outreach Department
1500 East Duarte Road
Main Medical Room 2101, Duarte, CA 91010-3000
Phone 844-313-5227 (LABS) | 626-218-0100
Fax 626-218-0736
cmdl@coh.org http://cmdl.cityofhope.org

CMDL Insurance TRF

Patient Information

Last Name	First name	Middle Initial	Female Male	Date of Birth
Street Address, State, ZIP			Phone Number	Client MRN
Specimen Type	Specimen Number	DNA source/concentration (accepted only if isolated by CLIA-certified or equivalent lab):		Date Collected
Marital Status: Single Married Divorced Separated Widowed		Ethnicity/Country or region of origin		

ICD10 Codes (required for insurance):

Diagnosis / Clinical Findings / Family History (please attach the pedigree if available, completed Patient Information Form and/or clinic notes)

Patient history	Family history

Insurance information (please attach a clear copy of the front and back of the insurance card/cards)

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

Authorization # (If an authorization is available please attach a copy of it or attach a LMN for HMO insurances)

For insurance billing, please choose one of the following options for after insurance is approved

- ☐ **Hold the test and inform the MD/GC if the patient out-of-pocket cost is more than $250**
- ☐ **Start the test immediately**

Referring Physician and Genetic Counselor (or other contact) Information

Referring Physician Name	Referring Physician UPIN	Genetic Counselor (or other contact) Name and Title	
Referring Physician Phone	Physician Institution and Address	Counselor/Contact Phone	Contact Institution and Address
Referring Physician Fax		Counselor/Contact Fax	
Referring Physician Email*		Counselor/Contact Email*	

Tests Ordered (multiple tests are done simultaneously unless the order of reflexive testing is noted here)

Comment:

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.

Referring Physician Signature (required):_____ **Date:** _____

For laboratory use only	Kindred #:	Accession #:	Specimen Type and Amount:
	Comments:		