GeneDx Portal Signatures Page

Please Note: This page is for use ONLY with orders submitted through the GeneDx Portal. Please be sure to include this form along with the order requisition form when submitting the patient sample.

Patient Information

Portal Order ID #: _____ (available ONLY after order is placed)

Patient Name: _____

DOB: _____

Patient Signatures

Patient Informed Consent: I have read the Informed Consent document and I give permission to GeneDx to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at GeneDx to improve genetic testing and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. I also give GeneDx permission to inform me or my health care provider in the future about research opportunities, including treatments for the condition in my family.

❒ Check this box if you wish to opt out of being contacted for research studies.

❒ Check this box if you do not wish to receive secondary findings (Exome Sequencing tests ONLY).

❒ Check this box if you are a New York state resident, and give permission for GeneDx to retain any remaining sample longer than 60 days after the completion of testing.

Patient Signature: _____ Date: _____

Patient Insurance Billing Consent: I represent that I am covered by insurance and authorize GeneDx, Inc. to give my designated insurance carrier, health plan, or third party administrator (collectively 'Plan') the information on this form and other information provided by my health care provider necessary for reimbursement. I authorize Plan benefits to be payable to GeneDx. I understand that GeneDx will attempt to contact me if my out-of-pocket responsibility will be greater than $100 per test (for any reason, including co-insurance and deductible, or non-covered services), and if I did not obtain an out-of-pocket estimate directly from the portal. If GeneDx is unsuccessful in its attempts to contact me, I understand that it will be my responsibility to contact GeneDx to determine my out-of-pocket cost and to pay my out-of-pocket responsibility. I will cooperate fully with GeneDx by providing all necessary documents needed for Plan billing and appeals. Additionally, if I receive an out-of-pocket estimate directly from the portal, I understand that it is my responsibility to contact GeneDx to discuss Plan billing and appeals. I understand that I am responsible for sending GeneDx any and all of the money that I receive directly from my Plan in payment for this test. Reasonable collection and/or attorneys fees, including filing and service fees, shall be assessed if the account is sent to collection but said fees shall not exceed those permitted by state law. I permit a copy of this authorization to be used in place of the original.

Medicare: A completed Advance Beneficiary Notice (ABN) is required for Medicare patients. Please visit our website, www.genedx.com/billing for more information.

Patient Signature: _____ Date: _____

Medical Professional Signature

Statement of Medical Necessity: This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the tests(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Medical Professional Signature (required): _____ Date: _____