

Patient Information

First name _____ Last name _____
 Gender Male Female Date of birth (mm/dd/yy) _____
 Ancestry Caucasian Eastern European Northern European
 Western European Native American Middle Eastern
 African American Asian Pacific Islander
 Caribbean Central/South American
 Ashkenazi Jewish Hispanic Other: _____

Mailing address _____
 City _____ State _____ Zip code _____
 Home phone _____ Work phone _____
 Email _____ Patient's primary language if not English _____

Sample Information

Medical record # _____ Specimen ID _____ Date sample obtained (mm/dd/yy) _____
 Blood in EDTA (5-6 mL in lavender top tube)
 DNA (>20 ug): Tissue source _____ concentration ____ (ug/ml) Vol ____ (ul)
 Oral Rinse (At least 30 mL of Scope oral rinse in a 50 mL centrifuge tube)
 Dried Blood Spots (2 cards) - **Not accepted for any testing with a del/dup component**
 Buccal Swab
 Other _____ (Call lab)
 Patient has had a blood transfusion Yes No Date of last transfusion ____/____/____
 (2-4 weeks of wait time is required for mtDNA testing only) Specimens are not accepted for patients who have had allogeneic bone marrow transplants
Clinical Diagnosis: _____ **ICD-10 Codes:** _____
Age at Initial Presentation: _____ **Add. ICD-10 Codes:** _____

Ordering Account Information

Acct # _____ Account Name _____
 Reporting Preference* Care Evolve Fax Email
**If unmarked, we will use the account's default preferences or fax to new clients.*

Physician _____ NPI # _____
 Genetic Counselor _____
 Street address 1 _____
 Street address 2 _____
 City _____ State _____ Zip code _____
 Phone _____ Fax (important) _____
 Email _____ Beeper _____

Send Additional Report Copies To:

Physician or GC/Acct # _____ Fax#/Email/CE # _____
 Physician or GC/Acct # _____ Fax#/Email/CE # _____

Statement of Medical Necessity

This test is medically necessary for the 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 the patient has consented to genetic testing.

Signature of Physician or Other Authorized NPI Provider (required) _____ Date _____

Patient Consent (sign here)

I have read the attached 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. **More information is available on our website: www.genedx.com**

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/Guardian Signature _____

Date _____

PATIENT STATUS – ONE MUST BE CHECKED: Hospital Inpatient Hospital Outpatient Not a Hospital Patient Hospital Patient Date of Discharge: _____

Payment Options

Insurance Bill

Referral/Prior Authorization # _____
Please attach copy of Referral/authorization
 Insurance Carrier _____ Policy Name _____ Hold sample for Estimated Benefit Investigation (only if OOP cost is >\$100) GeneDx Benefit Investigation # _____

Insurance ID # _____ Group # _____ Name of Insured _____ Date of Birth _____ Insurance Address _____ City _____ State _____ Zip _____
 Relationship to Insured Child Spouse Self Other _____

Secondary Insurance Carrier Name _____ Insurance ID# _____ Group # _____ Name of Insured _____ Date of Birth _____
 Relationship to Insured Child Spouse Self Other _____

Please include a copy of the front and back of the patient's insurance card (include secondary when applicable)

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 estimated out-of-pocket responsibility will be greater than \$100 per test (for any reason, including co-insurance and deductible, or non-covered services). 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. 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 attorney's 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.

Patient Signature (required) _____ Date _____

Institutional Bill

GeneDx Account # _____
 Hospital/Lab Name _____
 Contact Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone _____ Fax _____

Patient Bill

Amount _____
 If I have insurance coverage for this testing, I am electing to be treated as a self-pay patient for this testing. As such, I agree that neither GeneDx nor I will submit a claim to my insurance for this testing.
Please bill my credit card for the full amount stated above (all major cards accepted)
 MasterCard Visa Discover American Express

Name as it appears on card _____
 Account Number _____ Expiration date _____ CVC _____
 Signature _____ Date _____
For GeneDx Use Only

Account # _____ Account Name _____

Clinical diagnosis: _____

ICD-10 codes: _____

DETAILED MEDICAL RECORDS, CLINICAL SUMMARY, PICTURES AND FAMILY HISTORY MUST BE ATTACHED. CLINICAL INFORMATION IS CRUCIAL FOR ACCURATE INTERPRETATION OF RESULTS.

Current Diagnosis: _____

Age of Onset: _____

Unilateral Bilateral Disease

Consanguinity: Yes No

Intraocular Pressure: _____

ERG Results: _____

Please check all that apply. This is not a substitute for submitting clinical records.

Craniofacial/Ophthalmologic/Auditory

- Cataracts
- Cleft lip/palate
- Coloboma of eye
- CPEO (ophthalmoplegia)
- Ptosis
- Blindness
- Optic atrophy
- Retinitis pigmentosa
- Hearing loss
- Ototoxicity (aminoglycoside-induced)
- External ear malformation
- Facial dysmorphism - please describe: _____

- Night blindness
- Aniridia
- Nystagmus
- Photophobia
- Sensorineural hearing loss
- Conductive hearing loss
- Mixed hearing loss
- Audiogram results
- Other visual abnormality type: _____

Perinatal history

- Prematurity
- IUGR
- Oligohydramnios
- Polyhydramnios
- Cystic hygroma/increased NT

Growth

- Failure to thrive
- Growth retardation/short stature
- Overgrowth
- Macrocephaly
- Microcephaly

Physical/Cognitive Development

- Fine motor delay
- Gross motor delay
- Speech delay
- Intellectual disability/MR
IQ: _____
- Learning disability
- Developmental regression

Behavioral

- Autism spectrum disorder
- Autistic features
- Obsessive-compulsive disorder
- Stereotypic behaviors
- Other psychiatric symptoms

Cardiac/congenital heart malformations

- ASD
- VSD
- Coarctation of aorta
- Hypoplastic left heart

- Tetralogy of Fallot
- Cardiomyopathy
- Arrhythmia/conduction defect
- Other: _____

Cancer/Malignancy

- Age of onset: _____
- Tumor type: _____
- Location(s): _____
- Affected relatives: _____

Skin/Hair

- Abnormal hair: _____
 Quality/Quantity: _____
 Hair distribution: _____
- Abnormal nails: _____
- Abnormal pigmentation: _____
- Abnormal connective tissue: _____

- Blistering
- Ichthyosis
- Skin tumors/Malignancies
- Other: _____

Brain malformations/abnormal imaging

- Agenesis of the corpus callosum
- Holoprosencephaly
- Lissencephaly
- Cortical dysplasia
- Heterotopia
- Hydrocephalus
- Brain atrophy
- Periventricular leukomalacia
- Hemimegalencephaly
- Abnormalities of basal ganglia
- Other: _____

Neurological/Muscular

- Ataxia
- Chorea
- Dystonia
- Hypotonia
- Hypertonia
- Seizures (type: _____)
- Spasticity
- Exercise intolerance/easy fatigue
- Muscle weakness
- Stroke/stroke-like episodes
- Recurrent headache/migraine

Gastrointestinal

- Gastroschisis/omphalocele
- Pyloric stenosis
- Tracheoesophageal fistula
- Delayed gastric emptying
- Eosinophilic esophagitis
- Gastrointestinal reflux
- Recurrent vomiting
- Chronic diarrhea

- Constipation
- Chronic intestinal pseudo-obstruction
- Hirschsprung disease
- Hepatic failure
- Elevated transaminases

Skeletal/Limb abnormalities

- Contractures
- Club foot
- Polydactyly
- Syndactyly
- Scoliosis
- Vertebral anomaly
- Other: _____

Genitourinary abnormalities

- Ambiguous genitalia
- Hypospadias
- Hydronephrosis
- Undescended testis
- Kidney malformation
- Renal agenesis
- Renal tubulopathy
- Other: _____

Endocrine

- Diabetes mellitus:
 Type I Type II
- Hypothyroidism
- Hypoparathyroidism
- Pheochromocytoma/paraganglioma

Metabolic

- Ketosis
- Lactic acidemia/high CSF lactate
- Elevated pyruvate
- Elevated alanine
- Organic aciduria
- Low plasma carnitine
- CPK abnormalities

Hematologic/Immunologic

- Anemia/neutropenia/pancytopenia
- Immunodeficiency
- Other: _____

Other testing (summarize or attach reports):

- Chromosomes/FISH: _____
- Array CGH: _____
- Fragile X syndrome: _____
- Muscle biopsy: _____
- Other relevant results (clinical or research): _____

Additional relevant clinical info:

Account # _____ Account Name _____

First Name _____ Last Name _____ Date of Birth (mm/dd/yy) _____

Ophthalmology/Audiology Genetic Testing Menu

Xpanded Panels*

- J894 Nystagmus Xpanded Panel (~825 Genes) J905 Retinal Dystrophy Xpanded Panel (~875 Genes)

*Please contact GeneDx if samples are not available for both parents.

Multi-gene Eye Disorder Tests

- | | |
|---|---|
| <input type="checkbox"/> J957 Anophthalmia/Microphthalmia Panel (23 Genes) | <input type="checkbox"/> 577 Progressive External Ophthalmoplegia (PEO)/ Optic Atrophy Nuclear Gene Panel (55 genes) |
| <input type="checkbox"/> J958 Cataract Panel (86 Genes) | <input type="checkbox"/> 466 Stargardt Sequencing Panel(3 Genes) |
| <input type="checkbox"/> J956 Cone-Rod Dystrophy Panel (31 Genes) | <input type="checkbox"/> T006 Usher Syndrome Panel (10 Genes) |
| <input type="checkbox"/> J959 Congenital Stationary Night Blindness Panel (12 Genes) | <input type="checkbox"/> 704 65 mtDNA Point Variants Plus Large Deletions Panel (LHON and PEO, muscle biopsy recommended for PEO) |
| <input type="checkbox"/> J955 Familial Exudative Vitreoretinopathy Panel (FEVR) (4 Genes) | |
| <input type="checkbox"/> J960 Glaucoma Panel (37 Genes) | |
| <input type="checkbox"/> 554 Mito Genome Sequencing & Deletion Testing | |

Single Gene Eye Disorder Tests

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> 379 AIPL1 Gene Sequencing | <input type="checkbox"/> 514 CNGA3 Gene Sequencing | <input type="checkbox"/> 474 HESX1 Gene Sequencing | <input type="checkbox"/> 299 RDS (PRPH2) Gene Sequencing |
| <input type="checkbox"/> 3693 BCOR Gene Sequencing & Del/Dup | <input type="checkbox"/> 513 CNGB3 Gene Sequencing | <input type="checkbox"/> 412 IMPDH1 Gene Sequencing | <input type="checkbox"/> 298 RHO Gene Sequencing |
| <input type="checkbox"/> 370 BCOR P85L Variant | <input type="checkbox"/> 378 CRB1 Gene Sequencing | <input type="checkbox"/> 586 NR2E3 Gene Sequencing | <input type="checkbox"/> 4241 RLBP1 Gene Sequencing |
| <input type="checkbox"/> 403 BEST1 Gene Sequencing | <input type="checkbox"/> 353 CRX Gene Sequencing | <input type="checkbox"/> 431 NYX Gene Sequencing | <input type="checkbox"/> 326 RP2 Gene Sequencing |
| <input type="checkbox"/> 590 CABP4 Gene Sequencing | <input type="checkbox"/> 1342 FOXC1 Gene Sequencing | <input type="checkbox"/> 5213 PAX2 Gene Sequencing | <input type="checkbox"/> 345 RPE65 Gene Sequencing |
| <input type="checkbox"/> 587 CACNA1F Gene Sequencing | <input type="checkbox"/> 604 FOXE3 Gene Sequencing | <input type="checkbox"/> 491 PAX6 Gene Sequencing & Del/Dup | <input type="checkbox"/> 2985 RPGRIP1 Gene Sequencing |
| <input type="checkbox"/> 376 CEP290 Hot Spots | <input type="checkbox"/> 432 FRMD7 Gene Sequencing | <input type="checkbox"/> 1341 PITX2 Gene Sequencing | <input type="checkbox"/> 517 SAG c.926delA Mutation |
| <input type="checkbox"/> 506 CERKL Gene Sequencing | <input type="checkbox"/> 589 GNAT1 Gene Sequencing | <input type="checkbox"/> 2973 PRPF3 Gene Sequencing | <input type="checkbox"/> 518 SAG Remaining Exon Sequencing |
| <input type="checkbox"/> 296 CHM Gene Sequencing | <input type="checkbox"/> 588 GRM6 Gene Sequencing | <input type="checkbox"/> TB50 RB1 Gene Sequencing & Del/Dup | <input type="checkbox"/> 489 TRPM1 Gene Sequencing |
| <input type="checkbox"/> 417 CNGA1 Gene Sequencing | <input type="checkbox"/> 476 GUCA1A Gene Sequencing | <input type="checkbox"/> 427 RDH5 Gene Sequencing | <input type="checkbox"/> 2571 XLRSl (RS1) Gene Sequencing |
| | <input type="checkbox"/> 377 GUCY2D Gene Sequencing | | |

Hearing Loss Tests

- J806 Hearing Loss Test (130 genes) 124 GJB2 (connexin 26) gene sequencing
- 157 GJB6 (connexin 30) gene sequencing
- 906 GJB6 Deletion/Duplication analysis
- 572 SLC26A4 gene sequencing

Biological Parent Sample Information

Mother: First name: _____ Last name: _____ DOB: _____ Not available To be sent later** Asymptomatic Symptomatic

Father: First name: _____ Last name: _____ DOB: _____ Not available To be sent later** Asymptomatic Symptomatic

Other: First name: _____ Last name: _____ DOB: _____ To be sent later** Relationship to Proband: _____

*Additional samples must be received within 3 weeks

Family History of Eye Disorders and Hearing Loss

- No Known Family History
- Pedigree Attached
- Adopted

Relationship	Maternal	Paternal	Ear & ENT Disorder	Age at Dx
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Family Member Testing

Testing for known familial variant in a nuclear gene

- 9011 Testing for ONE known familial variant in a nuclear gene
- 9012 Testing for TWO known familial variants in a nuclear gene
- 905 Testing for ONE known familial exon-level del/dup or chromosomal microarray del/dup

Gene(s): _____ Variant(s): _____

Proband Name: _____

Proband GeneDx Acc#: _____ Relationship to proband: _____

- Positive control included - **Positive control is required if previous test was performed at another lab.**

- Family Member Test Report included - A clear copy of the test report on the variant positive family member is recommended if previous test was performed at another lab.

Additional Test

Test Code _____ Test Name _____

The following diagnosis codes are listed as a convenience only. Ordering physicians should use the ICD-10 code that best describes the reason for performing the test, whether or not that code is listed below.

Frequently Used ICD-10 Codes

Eye Disorders

- | | | |
|---|---|--|
| <input type="checkbox"/> Q12.0 Congenital cataract | <input type="checkbox"/> H26.039 Infantile and juvenile nuclear cataract, unspecified eye | <input type="checkbox"/> H35.52 Pigmentary retinal dystrophy |
| <input type="checkbox"/> Q15.0 Congenital glaucoma | <input type="checkbox"/> H55.0 Nystagmus | <input type="checkbox"/> H40.11 Primary open-angle glaucoma |
| <input type="checkbox"/> H55.01 Congenital nystagmus | <input type="checkbox"/> H55 Nystagmus and other irregular eye movements | <input type="checkbox"/> H26.9 Unspecified cataract |
| <input type="checkbox"/> H53.63 Congenital stationary night blindness | <input type="checkbox"/> H35.53 Other dystrophies primarily involving the sensory retina | <input type="checkbox"/> H35.50 Unspecified hereditary retinal dystrophy |
| <input type="checkbox"/> H35.023 Familial exudative vitreoretinopathy | | <input type="checkbox"/> H53.60 Unspecified night blindness |
| <input type="checkbox"/> H40 Glaucoma | | |
| <input type="checkbox"/> H35.5 Hereditary retinal dystrophy | | |

Hearing Loss Disorders

- | | |
|---|--|
| <input type="checkbox"/> H90 Conductive and sensorineural hearing loss | <input type="checkbox"/> H91.03 Ototoxic hearing loss, bilateral |
| <input type="checkbox"/> H90.0 Conductive hearing loss, bilateral | <input type="checkbox"/> H90.3 Sensorineural hearing loss, bilateral |
| <input type="checkbox"/> H90.2 Conductive hearing loss, unspecified | <input type="checkbox"/> H91.93 Unspecified hearing loss, bilateral |
| <input type="checkbox"/> H90.6 Mixed conductive and sensorineural hearing loss, bilateral | <input type="checkbox"/> Z82.2 Family history of deafness and hearing loss |

I understand that my health care provider has ordered the following genetic testing for {me/my child}: _____.

General Information About Genetic Testing

What is genetic testing?

DNA provides instructions for our body's growth and development. Genes are distinct sequences of DNA, and are arranged on chromosomes. The DNA in a gene contains instructions for making proteins, which determine things like growth and metabolism as well as traits like eye color and blood type. Genetic disorders are caused by certain changes in DNA affecting the structure or number of chromosomes. Genetic testing is a laboratory test that tries to identify these changes in chromosomes or the DNA. Genetic testing can be a diagnostic test, which is used to identify or rule out a specific genetic condition. Genetic screening tests are used to assess the chance for a person to develop or have a child with a genetic condition. Genetic screening tests are not typically diagnostic and results may require additional testing.

The purpose of this test is to see if I, or my child, may have a genetic variant or chromosome rearrangement causing a genetic disorder or to determine the chance that I, or my child, will develop or pass on a genetic disorder in the future. 'My child' can also mean my unborn child, for the purposes of this consent.

If I/my child already know the specific gene variant(s) or chromosome rearrangement that causes the genetic disorder in my family, I will inform the laboratory of this information.

What could I learn from this genetic test?

The following describes the possible results from the test:

1) Positive: A positive result indicates that a genetic variant has been identified that explains the cause of my/my child's genetic disorder or indicates that I/my child am at increased risk to develop the disorder in the future. It is possible to test positive for more than one genetic variant.

2) Negative: A negative result indicates that no disease-causing genetic variant was identified by the test performed. It does not guarantee that I/my child will be healthy or free from genetic disorders or medical conditions. If I/my child test negative for a variant known to cause the genetic disorder in other members of my/my child's family, this result rules out a diagnosis of the same genetic disorder in me/my child due to this specific change.

3) Inconclusive/Variant of Uncertain Significance (VUS): A finding of a variant of uncertain significance indicates that a genetic change was detected, but it is currently unknown whether that change is associated with a genetic disorder either now or in the future. A variant of uncertain significance is not the same as a positive result and does not clarify whether I/my child is at increased risk to develop a genetic disorder. The change could be a normal genetic variant or it could be disease-causing. Further analysis may be recommended, including testing parents and other family members. Detailed medical records or information from other family members also may be needed to help clarify results.

4) Unexpected results: In rare instances, this test may reveal an important genetic change that is not directly related to the reason for ordering this test. For example, this test may tell me about the risk for another genetic condition I/my child is not aware of or it may indicate differences in the number or rearrangement of sex chromosomes. This information may be disclosed to the ordering health care provider if it likely impacts medical care.

Result interpretation is based on currently available information in the medical literature, research and scientific databases. Because the literature, medical and scientific knowledge are constantly changing, new information that becomes available in the future may replace or add to the information GeneDx used to interpret my/my child's results. Providers can contact GeneDx at any time to discuss the classification of an identified variant. In addition, I or my/my child's health care providers may monitor publicly available resources used by the medical community, such as ClinVar (www.clinvar.com), to find current information about the clinical interpretation of my/my child's variant(s).

For tests that evaluate data from multiple family members, my spouse, or partner concurrently, results may be included in a single comprehensive report.

What are the risks and limitations of this genetic test?

- Genetic testing is an important part of the diagnostic process. However, genetic tests may not always give a definitive answer. In some cases, testing may not identify a genetic variant even though one exists. This may be due to limitations in current medical knowledge or testing technology.
- Accurate interpretation of test results may require knowing the true biological relationships in a family. Failing to accurately state the biological relationships in my/my child's family may result in incorrect interpretation of results, incorrect diagnoses, and/or inconclusive test results. In some cases, genetic testing can reveal that the true biological relationships in a family are not as they were reported. This includes non-paternity (the stated father of an individual is not the biological father) and consanguinity (the parents of an individual are related by blood). It may be necessary to report these findings to the health care provider who ordered the test.
- Genetic testing is highly accurate. Rarely, inaccurate results may occur for various reasons. These reasons include, but are not limited to: mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or unusual circumstances such as bone marrow transplantation, or the presence of change(s) in such a small percentage of cells that the change(s) may not be detectable by the test (mosaicism).
- This test does not have the ability to detect all of the long-term medical risks that I/my child might experience. The result of this test does not guarantee my health or the health of my child/fetus. Other diagnostic tests may still need to be done, especially when only a genetic screening test has been performed previously.
- Occasionally, an additional sample may be needed if the initial specimen is not adequate.

Patient Confidentiality and Genetic Counseling

It is recommended that I receive genetic counseling before and after having this genetic test. I can find a genetic counselor in my area here: www.nsgc.org. Further testing or additional consultations with a health care provider may be necessary.

To maintain confidentiality, the test results will only be released to the referring health care provider, to the ordering laboratory, to me, to other health care providers involved in my/my child's diagnosis and treatment, or to others as entitled by law. The United States Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, I understand that I can visit www.genome.gov/10002077.

International Specimens

If I/my child reside outside the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of my/my child's residence.

Additional information about the specific test being ordered is available from my health care provider or I can go to the GeneDx website, www.genedx.com. This information includes the specific types of genetic disorders that can be identified by the genetic test, the likelihood of a positive result, the limitations of genetic testing, as well as information about how specimens and information are stored and used.

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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