CHANGE IN TESTING AUTHORIZATION FORM

Completed form can be faxed to: (201) 421-2010 or E-mailed to: zebras@genedx.com

GeneDx Accession:		Date:	
Account Number:		From:	
Requested By:		Number of Pages:	
Attention To:		Fax Number:	

CLINICIANS, PLEASE ROUTE YOUR REQUESTS THROUGH THE IN-HOUSE OR LOCAL LAB THAT HANDLED THE INITIAL SPECIMEN.

Patient Last Name *Patient First Name* *Patient Middle Name* *Patient DOB (mm/dd/yyyy)*

TEST CODE	TEST NAME	ADD	CANCEL
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

DIAGNOSIS (DX) CODE(S)

DX codes:

I (i) authorize GeneDx to make changes to the original test requisition form, (ii) certify that I am the ordering provider, and (iii) I am authorized by law to order the test(s) requested.

Signature of Ordering Provider *Date*

If ordering physician and/or payment method has changed, please submit a new test requisition form, available on our website, **www.genedx.com.**

BILLING

☐ **INSTITUTIONAL BILLING** *(TEST MUST BE ORDERED BY THE SAME ACCOUNT)*
APPROVED BY:

Ordering Provider Name (print clearly)

Ordering Provider Signature *Date*

Responsible Laboratory/ Institution (Please include institution address or institutional stamp)

☐ **INSURANCE** *(COPY OF INSURANCE CARD* ***MUST BE*** *INCLUDED)*
☐ Commercial ☐ Medicare ☐ Medicaid

Patient is responsible for cost share amounts

Insurance Carrier *Insurance ID*

POLICY HOLDER'S RELATIONSHIP TO INSURED: ☐ Patient ☐ Spouse ☐ Child ☐ Other: ____________

Policy Holder's Name *Policy Holder's DOB*

☐ HOLD FOR BENEFITS INVESTIGATION

ORDERED BY:

Ordering Provider Name (print clearly)

Ordering Provider Signature *Date*

☐ **SELF-PAY** *(PATIENT WILL RECEIVE AN INVOICE) PLEASE BE AWARE THAT, IN ALL CASES, THE PATIENT HAS FULL FINANCIAL RESPONSIBILITY FOR SELF-PAY*

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