CHANGE IN TESTING AUTHORIZATION FORM

Clinicians, please route your requests through the in-house or local lab that handled the initial specimen.

GeneDx Accession		Date	
Account Number		From	
Portal Order ID		Attention To	

Patient Name	Patient DOB (MM/DD/YY)

TEST CODE	TEST NAME	PERFORM	CANCEL
		☐	☐
		☐	☐
		☐	☐
		☐	☐

For exome and genome sequencing tests, please list name, date of birth, relationship, and affected status of any relatives to be submitted for testing in the comments box below. Note that for exome and genome sequencing, individuals will be opted in to receive ACMG secondary findings unless a patient signed ACMG consent form is received designating their desire to opt out. This testing also requires submission of clinical information.

DIAGNOSTIC CODE(S) AND PATIENT STATUS

ICD-10 diagnosis code(s) to the highest level of specificity for the patient:

Patient Status: Is this individual currently a Hospital Inpatient? ○ Yes ○ No

PROVIDER ATTESTATION

By signing this form, the ordering provider attests that (i) he/she authorizes and directs GeneDx to perform the testing indicated; (ii) he/she is the ordering provider and is authorized by law to order the test(s) requested; (iii) any test(s) requested on this Test Requisition Form ("TRF") are reasonable and medically necessary for the diagnosis or treatment of a disease, illness, impairment, symptom, syndrome or disorder; (iv) the test results will determine the patient's medical management and treatment decisions of this patient's condition on this date of service; (v) the patient or the individual/family member authorized to make decisions for the patient (collectively, the "patient"), in addition to any relatives', when applicable, has been supplied with information regarding genetic testing, and has consented to undergo genetic testing; (vi) the full and appropriate diagnosis codes are indicated to the highest level of specificity; (vii) he/she will not seek reimbursement from any third party, including but not limited to federal healthcare programs if testing is covered by GeneDx and will inform the patient of the same; (viii) GeneDx may share contact information for the ordering provider and other healthcare providers listed on the this order with third parties regarding the requested genetic testing and potential clinical trial or study opportunities; and (ix) the patient or the individual/family member authorized to be contacted via the email address or mobile phone number provided for this and future testing.

Ordering Provider Name	NPI

Send Report Via: ○ Portal ○ Email: ______________________ ○ Fax: ______________________

Signature of Ordering Provider (OP) or individual authorized to sign on behalf of OP	Date

For insurance billing, healthcare providers may request a cost estimate for certain commercial insurance plans. Please contact GeneDx if this is desired and was not initially requested on the original order.

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

☐ SEE COMMENTS BELOW

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