Machaon Diagnostics

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aHUS Genetic Panel 3.0 Order Form

STAT Turnaround Time: 48 hours, M-F / Routine Turnaround Time: 1 week

MachaonDiagnostics.com
1-800-566-3462

PATIENT INFORMATION (complete or attach)

Patient's Name: (Last, First, M.I.) *required*	Sex: *required* ◯ M ◯ F
Specimen Date and Time: *required*	DOB: (MM/DD/YYYY) *required*
MRN: *required*	Accession #:

SUBMITTING FACILITY

Facility Name and Address: *required*

Facility Phone Number: *required* Fax Number for Results: *required*

ORDERING PHYSICIAN INFORMATION

Physician's Name: (Last, First, M.I.) *required*	Physician's NPI:
Contact Phone Number:	Fax Number for Results:
Physician's direct phone number to call results: (***highly encouraged***)	

BILLING INFORMATION

Bill to: ☐ **Facility / Inpatient or Outpatient**

Bill to: ☐ **Insurance / Outpatient** These services are FREE for outpatients that qualify for our Sponsored Testing Program.

☐ ***STAT*** ***(48-hr TAT, M-F)*** *Mark 'SATURDAY Delivery' if shipping Friday.*

CLINICAL INFORMATION (if available)

ADAMTS13: _____ (%) Inhibitor (+/-):_____

Note: We offer this test with a 24-hour turnaround time. Please call for draw kits.

Has this patient had a bone marrow transplant? ◯ Yes ◯ No ◯ Unknown

PLT Count: _____ (K/μL)
Hemoglobin: _____ (mg/dL)

Shiga toxin (+/-):___
LDH: _____ (U/L)

Eculizumab therapy: ◯ Yes ◯ No

Ethnicity: ☐European ☐African ☐Latino ☐East Asian ☐South Asian
or other:_____

TEST SELECTION

☐ aHUS Genetic Panel	(EDTA whole blood)	*NY-state approved LDT NGS panel containing 20 genes. (See website for gene list)*
☐ CFH Region Del/Dup	(EDTA whole blood)	NY samples require a limited permit approval for this test.
☐ CFH Autoantibody (serum)		NY samples require a limited permit approval for this test.

Informed Consent for Genetic Testing (required for patients drawn in New York state)

Providers are required to obtain informed consent from patients for genetic testing for all genetic samples originating in New York. An informed consent form may be found at http://www.machaondiagnostics.com, with a description of the test, purpose, and limitations. In lieu of submitting a copy of the signed informed consent, healthcare providers may sign the below statement attesting that informed consent has been obtained.
Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test ordered on this requisition and I authorize testing of the provided specimen.

Signature of Provider:_____ Date:_____
Note: testing may be delayed if a consent form is not received or the provider signature is present above.

OUTPATIENT ONLY: INSURANCE BILLING INFORMATION (complete or attach)

Insurance Company: (***Medicare patients must sign ABN***)		Patient Address:	Patient Phone Number:
Insurance Policy / Medicare Number:	Insurance Group Number:	Patient City:	State: Zip Code:
Insurance Company Address:	Authorization Number:		
Insurance Company City:	State: Zip Code:		

DIAGNOSIS CODE(S):

(Please complete medical necessity form.)

ICD-10 Code: ICD-10 Code: ICD-10 Code:

OUTPATIENT ONLY: PATIENT SIGNATURE

Machaon Diagnostics may need to obtain additional information from your physician to complete these services. I hereby authorize the release of medical information related to the services described herein and authorize payment directly to Machaon Diagnostics. This test is currently not covered or reimbursed by Medicare or Medicaid. The aHUS Genetic Panel is $3,067 and if ordered STAT, add $770; shipping charges may apply. I agree to assume responsibility for payment of all charges not covered by my healthcare insurer.

Patient's Signature:
X: _____ Date: _____.

ADDITIONAL INFORMATION

Machaon Diagnostics is a specialized coagulation, platelet, complement and genetics laboratory that provides clinical reference laboratory services. Most evaluations can be completed within 24 hours, 7 days a week. Machaon Diagnostics is a multi-state-licensed, CLIA-accredited, CAP-accredited, clinical laboratory approved to provide high-complexity testing services. These tests are not covered or reimbursed by Medicare or Medicaid. All patients are considered OUT-OF-NETWORK and will be billed for services not covered by their insurance provider. Medicare patients must sign an ABN, downloadable from the Machaon Diagnostics website. Patient insurance billing services are provided in accordance with the Machaon Insurance Billing Policy. HMO or medical group covered patients may need a prior authorization if they seek full reimbursement. For more information please visit ***www.MachaonDiagnostics.com*** or call (800) 566-3462. **Note: These services are FREE for outpatients that qualify for our Sponsored Testing Program; please call to inquire.**

MDI Use: (Order number): _____ (Number of aliquots): _____ Date and time received: _____