BCM
Baylor College of Medicine

MEDICAL GENETICS LABORATORIES

1-800-411-4363 Fax: 713-798-6584 www.bcmgeneticlabs.org

BIOCHEMICAL TEST REQUISITION

SHIP TO: **MEDICAL GENETICS LABORATORIES**
Baylor College of Medicine
2450 Holcombe, Grand Blvd. - Receiving Dock
Houston, TX 77021-2024

!STOP IMPORTANT BILLING INFORMATION!
Indicate Institution Billing Code here: _____, **OR** complete and fax billing information form (page 2 of requisition) to 713-798-4187. **Samples received without the Institution Code or Billing Form cannot be processed.**

FOR PRENATALS, PLEASE USE PRENATAL REQUISITION FORM.

DATE SAMPLE OBTAINED (MM/DD/YY): _____/_____/_____

PATIENT DATA

NAME (Last, First, Middle Initial): _____
DATE OF BIRTH (MM/DD/YY): _____/_____/_____
Please check one: ☐ MALE ☐ FEMALE ☐ UNKNOWN
HOSPITAL #: _____
ACCESSION #: _____

REPORTING INFORMATION

PHYSICIAN/INSTITUTION: _____
ADDRESS: _____
_____
CITY, STATE, ZIP: _____
PHONE #: (_____) _____ FAX #: (_____) _____
Additional Reports to:
1. NAME: _____ FAX #: (_____) _____
2. NAME: _____ FAX #: (_____) _____

ANALYTE TEST REQUESTED

4100 ☐ Amino Acids Analysis - Plasma
4160 ☐ Amino Acids Analysis - CSF
4240 ☐ Amino Acids Analysis - Urine
4300 ☐ Acylcarnitine/Carnitine Combination - Plasma
4310 ☐ Carnitine, Free and Total - Plasma
4130 ☐ Creatine/Guanidinoacetate Analysis - Plasma
4260 ☐ Creatine/Guanidinoacetate Analysis - Urine
4627 ☐ Cystine, White Blood Cell - Heparinized Blood
4140 ☐ Homocysteine, Total Plasma
4150 ☐ Methylmalonic Acid - Plasma
4200 ☐ Organic Acid Screen - Urine
4210 ☐ Orotic/Orotidine Analysis - Urine
4110 ☐ Phenylalanine/Tyrosine - Plasma
4340 ☐ Polyols, Urinary
4220 ☐ Purine Panel - Urine
4250 ☐ Succinylacetone - Urine
4330 ☐ Thymidine - Plasma

ENZYME TEST REQUESTED

DISEASE NAME	SAMPLE TYPE				
	RBC	Serum	SFC	WBC	Other
☐ Adenosine Deaminase Deficiency	○ 4509		☐ 4510	☐ 4511	
☐ Argininemia	○ 4536				☐ 4535 (L)
☐ Argininosuccinate Lyase Deficiency	○ 4524		☐ 4525		☐ 4523 (L)
☐ Aspartylglucosaminuria			☐ 4514		
☐ Biotinidase		○ 4555			
☐ Carbamyl Phosphate Synthetase Deficiency					○ 4561 (L)
☐ Citrullinemia			○ 4545		☐ 4544 (L)
☐ Fabry Disease			☐ 4516	○ 4517	
☐ Fucosidosis			☐ 4512	○ 4513	
☐ Galactosemia (UDPG Transferase)	○ 4619				
☐ Gaucher Disease			☐ 4553	○ 4554	
☐ Glucuronidase Deficiency (Sly, MPSVII)		○ 4550	☐ 4551		
☐ GM1 Gangliosidosis (Morquio B, MPS IV B)			☐ 4548	○ 4549	
☐ Hurler Disease (Hurler-Scheie, MPS I)			☐ 4575	○ 4576	
☐ Krabbe Disease			☐ 4565	○ 4566	
☐ Lesch-Nyhan Disease	○ 4572		☐ 4573		
☐ Lowe Syndrome			○ 4585		
☐ Mannosidosis		☐ 4526	☐ 4527	○ 4528	
☐ Maroteaux-Lamy (MPS VI)			☐ 4540		
☐ Metachromatic Leukodystrophy			☐ 4537	○ 4538	
☐ Niemann-Pick Disease			☐ 4607	○ 4608	
☐ Ornithine Transcarbamylase Deficiency					○ 4582 (L)
☐ Purine Nucleoside Phosphorylase Deficiency	○ 4592		☐ 4593	☐ 4594	
☐ Pompe Disease			○ 4520		○ 4519 (M)
☐ Sanfilippo B Mucopolysaccaridosis (MPS III)		○ 4579	☐ 4580		
☐ Sialidosis (Neuraminidase Deficiency)			○ 4603		
☐ Tay-Sachs Disease		○ 4569			
☐ Tay-Sachs Disease Carrier Testing		○ 4617			
☐ Wolman Disease (Cholesterol Ester Storage Disease)			☐ 4503	○ 4504	☐ 4502 (L)
☐ X-Linked Ichthyosis (Steroid Sulfatase Deficiency)			☐ 4614	○ 4615	

* ○ - Preferred specimen type.
Sample types are: Serum; RBC - Red Blood Cells; WBC - White Blood Cells; SFC - Skin Fibroblast Culture; M - Muscle; L - Liver.

PLEASE CONSULT THE LABORATORY PRIOR TO SUBMITTING SKIN FIBROBLAST CULTURES.

7/2008

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P. O. Box 4832 • Houston, TX 77210-4832 • 713-798-8923
Fax: 713-798-4187 • www.bcmgeneticlabs.org • medgenbilling@bcm.edu

BILLING INFORMATION FORM

STOP! ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
The Self-Pay option must include payment with sample. We require and provide insurance pre-verification service. Please fax the *Patient Insurance Verification Form* (available at www.bcmgeneticlabs.org) to 713-798-4187. If the Billing Information section is incomplete, the referring physician, hospital, or laboratory will automatically be billed, or sample processing suspended. Please forward billing questions to: medgenbilling@bcm.edu

PATIENT INFORMATION:

Name (Last, First, Middle Initial): _____
Address: _____
City, State, Zip: _____
Phone #: (_____) _____ Email: _____

PAYMENT OPTIONS:

1. ☐ **Institution or referring MD Code (as assigned by BCM):** _____
   (or) Institution Name: _____
   Billing Address: _____
   City, State, Zip: _____
   Financial Contact: _____
   E-mail (required): _____
   Phone #: (_____) _____ Fax #: (_____) _____

2. ☐ **Self-Pay: Check, Money Order, or Credit Card payment must accompany sample.**
   Credit Card (Please check one): ☐ AMEX ☐ Discover ☐ MC ☐ VISA
   Valid Card #: _____ Exp date (mm/yy): ____ /____ **CVC Code:** _____
   Cardholder printed name: _____
   Cardholder signature: _____

3. ☐ **Insurance:** Please refer to the Financial Policy at http://www.bcm.edu/geneticlabs/billing.html for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required authorizations. We do not file out-of-state Medicaid. Prenatal CMA requires a prepayment amount. Contact medgenbilling@bcm.edu with questions.

   ICD9 Diagnosis Code(s) must be provided or insurance cannot be filed: **ICD-9 CODE:** _____
   ☐ PPO, Commercial Insurance-provide Patient Insurance Verification form (PIVF) and front/back copy of card
   ☐ HMO-provide PIVF, authorization, front/back copy of insurance card
   ☐ Texas Medicaid/Texas Medicaid HMO-provide PIVF, authorization, front/back copy of Medicaid card

   Insured Policyholder's Information:
   Name: _____ Date Of Birth (mm/dd/yy): ____/____/____
   Insured SS or ID #: _____ Gender (Please check one): ☐ M ☐ F
   Authorization: _____
   Relationship to Patient: _____
   Insurance Name: _____
   Employer: _____ Group #: _____
   Insurance Address: _____
   Insurance City, State, Zip: _____
   Insurance Phone #: (_____) _____

I authorize BCM Medical Genetics Laboratories to furnish any medical information requested on myself, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to BCM Medical Genetics Laboratories. I understand I am responsible for any co-pay, deductible, or non-covered service amounts. I understand I am fully responsible for payment of my account if the BCM Medical Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Printed Name: _____

Signature: _____ Date (mm/dd/yy): _____/_____/_____