



MYRIAD GENETIC LABORATORIES, INC.
 A CLIA Certified Laboratory
 320 Wakara Way • Salt Lake City, Utah 84108
 (800) 469-7423 • (801) 584-1100
 Fax (801) 584-3615 • info@myriad.com

Test Request Form
ENTIRE FORM MUST BE COMPLETED
Infusional 5-FU from Plasma

NOTE: Affix Bar Code Label to Specimen Tube.

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE) _____ NPI# _____

MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800) 469-7423)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

OFFICE CONTACT _____ PHONE _____ FAX _____ E-MAIL _____

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL) _____ PT ID (Optional) _____ SSN _____ FEMALE BIRTH DATE (MM/DD/YYYY) _____
 MALE

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ DAYTIME PHONE NUMBER _____ ALTERNATE PHONE NUMBER _____

CLINICAL HISTORY

WHAT KIND OF CANCER DOES THIS PATIENT HAVE?

COLORECTAL Other Cancer: _____ Metastatic OR Adjuvant

ICD-9 CODE(s)/Dx: _____

WHAT INFUSIONAL 5-FU CHEMOTHERAPY REGIMEN IS THIS PATIENT RECEIVING?

FOLFOX + AVASTIN FOLFOX FOLFIRI Other: _____

What is the infusional 5-FU dose? _____ mg/m²

Time of 5-FU continuous infusion start: Date: _____ Time: _____ am pm
MM/DD/YYYY

Time of blood draw for sample: Date: _____ Time: _____ am pm
MM/DD/YYYY

Infusion duration: _____ hrs

IMPORTANT! Blood sample must be drawn while infusion is in process, at least 2 hours after the start time.

Once drawn, immediately place sample on ice; centrifuge within 45 minutes; prior to shipping, plasma must be transferred to transfer tube: see Sampling Instructions for detailed procedures.

BILLING/PAYMENT INFORMATION

OPTION 1: PLEASE BILL MY INSURANCE
 Option 1 requires patient signature and enlarged copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

Name of Insured: _____ DOB: _____ Insurance ID#/ SSN: _____

Patient Relationship to Insured: Self Spouse Child Other

Authorization/Referral #: _____ (Please attach copy of authorization/referral)

I hereby authorize Myriad Genetic Laboratories, Inc. (MGL) to furnish 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 if necessary for reimbursement. I also authorize all benefits of the plan to be payable to MGL. If required by my Plan, I agree to assist in submitting appeals for payment, and understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____ Date: _____

REMINDER: INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S)

OPTION 2: PATIENT PAYMENT (Please call Customer Service for questions regarding test prices.)

Please bill my credit card (all major credit cards accepted) in the amount of \$ _____ Card# _____ Exp. Date: _____

Cardholder Name (please print): _____ Cardholder Signature: _____

Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.

OPTION 3: OTHER BILLING

Bill our institutional account #: _____ (to establish an account, submit billing information with this form).
 Established research project code #: _____

Myriad has authorized research testing for this patient. "MGA" number assigned: _____