SECURE HEALTH

FAX - TIME SENSITIVE
PLEASE RETURN TO SECURE HEALTH FAX: 801-509-6879

To:
Fax:
Phone:
Date:
Subject:
Comments: PATIENT REQUESTED

Your patient _____, is requesting a hereditary cardiac screening due to concerns with their personal or family history. Secure Health would like to include you in the process because you are the patients primary care physician and can help in the implementation of the results of the test into the patient's existing care plan. **Please sign the attached requisition form, the physician authorization form, and the certificate of medical necessity. The results will be sent via fax or via online portal, depending on preference.**

Also, please note that the attached ICD-10 codes are typically associated with medical necessity for hereditary cardiac screenings, but do not guarantee
coverage for any genetic test. Providers are NOT required to use the attached examples. Secure Health and all associated companies do require ICD-10 codes that are:

1. Patient specific
2. Prove the medical necessity to support testing
3. Are billable to the highest specificity

Samples that are received without proper ICD-10 coding will be held for 30 days. After this period, if the correct ICD-10 codes are not included, the sample will be destroyed.

With any questions, please contact Secure Health at (801) 477-0474

Laboratory Request

ATCG
Advanced Testing in Clinical Genetics

Shih-Jwo Huang, M.D., Ph.D.
Laboratory Director
CLIA # 05D2104354

Tel 949 393 5600 | Fax 888 859 4350 | 18 Technology Drive, Suite 107 | Irvine, CA 92618

AFFIXED LABEL PT 1

SPECIMEN INFORMATION

DATE COLLECTED / / TIME COLLECTED : AM PM

☐ Swabs rubbed firmly in each cheek and under the gum

Initial of person collecting sample _____

SPECIMEN ID NUMBER

TEST REQUISITION

Patient Information

Patient Last Name

Patient First Name, Middle Initial

Gender ☐ M ☐ F

☐ **Uninsured Patient**

Patient Social Security Number — —

Date of Birth / /

Date of Injury / /

If Workers' Comp

Patient Work Phone - -

Ext.

Patient Home Phone - -

Patient Cell Phone - -

Race
☐ African American ☐ Asian
☐ Caucasian ☐ Hispanic
☐ Other:

Practice Information

Requesting Provider _____

Billing Information

BILL TO: ☐ Insurance ☐ Medicaid ☐ Self-Pay ☐ Medicare*#:

**When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.*

PRIMARY INSURANCE *(Attach front & back copy of card)*
Responsible Party/Policy Holder | Relation
I.D. or Policy # | Group #

SECONDARY INSURANCE *(Attach front & back copy of card)*
Responsible Party/Policy Holder | Relation
I.D. or Policy # | Group #

Diagnosis Code(s)

REQUIRED

PLEASE COMPLETE ALL GREEN HIGHLIGHTED SECTIONS.

ORDER TESTS

Tests Requested

☐ **Actionable Cardio Gene Panel**

A2ML1, ABCC9, ACADVL, ACTA2, ACTB, ACTC1, ACTG1, ACTN2, ACVR2B, ACVRL1, ADA2, AGL, AKAP9, ALMS1, ANK2, ANKRD1, APOA5, APOB, B4GALT7, BAG3, BBS10, BCOR, BMPR2, BRAF, C1R, C1S, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CALR3, CASQ2, CAV1, CAV3, CAVIN4, CBL, CBS, CCDC103, CCDC39, CCDC40, CHD7, CHRM2, COL3A1, COL5A1, COL5A2, COX15, CPT1A, CPT2, CRELD1, CRYAB, CSRP3, CTF1, CTNNA3, DEPDC5, DES, DMD, DNAAF1, DNAAF2, DNAAF3, DNAAF4, DNAAF5, DNAH11, DNAH5, DNAI1, DNAI2, DNAJC11, DNAJC19, DNAL1, DOLK, DSC2, DSG2, DSP, DTNA, EFEMP2, ELAC2, ELN, EMD, ENG, EYA4, FBN1, FBN2, FGD1, FHL1, FHL2, FKRP, FKTN, FLNA, FLNC, FOXH1, FXN, GAA, GATA4, GATA6, GATAD1, GDF1, GJA1, GJA5, GLA, GPC3, GPD1L, GYG1, HAMP, HAND1, HCN4, HFE, HJV, HRAS, ILK, INVS, JAG1, JPH2, JUP, KAT6B, KCNA5, KCND3, KCNE1, KCNE2, KCNE3, KCNE5, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNK3, KCNQ1, KCNQ2, KCNQ3, KCNT1, KRAS, LAMA4, LAMP2, LDB3, LDLR, LDLRAP1, LEFTY2, LMNA, LZTR1, MAP2K1, MAP2K2, MED12, MED13L, MFAP5, MIB1, MKS1, MMP21, MRPL3, MTO1, MYBPC3, MYH11, MYH6, MYH7, MYL2, MYL3, MYLK, MYLK2, MYOM1, MYOZ2, MYPN, NDUFAF1, NDUFB11, NEBL, NEK8, NEXN, NF1, NKX2-5, NKX2-6, NME8, NODAL, NOTCH1, NPHP3, NPPA, NR2F2, NRAS, NSD1, OFD1, PCDH19, PCSK9, PDLIM3, PKD1L1, PKP2, PLN, PLOD1, PRDM16, PRKAG2, PRKG1, PRRT2, PSEN2, PTPN11, RAF1, RANGRF, RASA1, RBM20, RIT1, RRAS, RYR2, SCN10A, SCN1A, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SCN8A, SCN9A, SDHA, SGCD, SHOC2, SKI, SLC22A5, SLC25A20, SLC2A1, SLC2A10, SLC40A1, SLMAP, SMAD3, SMAD4, SMAD6, SMAD9, SNTA1, SOS1, SOS2, SPRED1, SYNE1, TAZ, TBX1, TBX20, TBX5, TCAP, TFR2, TGFB2, TGFB3, TGFBR1, TGFBR2, TMEM43, TMEM70, TMPO, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRPM4, TTC8, TTN, TTR, TXNRD2, VCL, YWHAE, ZFPM2, ZIC3

Patient's Consent

I, the undersigning request and authorize ATCG Laboratory to perform the tests requested above on the sample(s) provided by me. ATCG Laboratory also has my permission to outsource the processing of sample(s) at their discretion. My signature below acknowledges that I have been informed of the benefits and limitations of the test(s) and that they have been explained to my satisfaction by a qualified healthcare professional.

I authorize ATCG Laboratory to bill my insurance company directly and to receive payment from them on my behalf. I further authorize my insurance company to pay ATCG Laboratory directly for services rendered. I acknowledge that I am ultimately responsible for payment of my account and any and all charges associated with its collection.

I authorize ATCG Laboratory or their designee to appeal on my behalf in the event of an underpayment or denial by my insurance carrier and to provide the information and actions necessary to reverse the denial and receive reimbursement for the unpaid claim.* This authorization is to remain valid until the charges for the orders on this form are paid in full.

By signing below, I certify that I provided my unadulterated specimen(s) to the collector to be analyzed; that the information provided on this form and on the label affixed to each specimen is correct; and each specimen to be tested was sealed in my presence. I acknowledge that the laboratory has my permission to release my results directly to the treating physician or facility. I allow the release of any medical information necessary to process the claim and I acknowledge that ATCG Laboratory may be an out of network provider with my insurer. I further agree that should my insurance provider send payment(s) directly to me that I will endorse the insurance check(s) and forward it to ATCG Laboratory within 30 days. I understand that failure to do so may result in my account being forwarded to collections and reported to a credit bureau.

**ATCG Laboratory and/or designee are not obligated to perform this appeal on my behalf.*

Patient Signature: _____ *Date:* _____

Physician/Authorizing Medical Professional's Signature

Physician Signature: _____ *Date:* _____

Follow instructions in the collection kit to obtain and ship samples. To avoid a delay in sample processing, include photocopy of insurance card(s) (front and back), and a copy of this form in the pre-paid shipping envelope included in the collection kit. NOTE: Sample cannot be processed without all necessary information.

ATCG LABORATORY COPY – WHITE I PHYSICIAN COPY – PINK

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v01.2020

Letter of Medical Necessity

Cardiac Conditions Hereditary Assessment

Date: _____

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Insurance Company: _____
Subscriber Name: _____
Policy #: _____

Dear Claims Specialist,
I'm writing this letter on behalf of my patient, _____ , to request coverage for the **Hereditary Assessment for Cardiac Conditions**, a genetic test offered through **Advanced Testing in Clinical Genetics (ATCG)**. This genetic testing is performed in a CLIA certified laboratory located in Irvine, CA.

This patient is suspected to have genetic predisposition to cardiac problems.
Patient has a family history for _____.
Personal and/or family history is suggestive of a higher risk for cardiac disease. I would like to assess this patient's future cardiac risk by performing genetic testing for **Hereditary Assessment for Cardiac Conditions**. The result of this genetic test will have a direct impact on the patient's treatment and management.

Test Information and Impact of Results on Medical Management
Cardiac Arrest, not to be confused with heart attack, occurs when the heart stops beating as a whole. It is the leading cause of non-traumatic death in the United States with genetic factors covering 25% of cardiac arrest. Mutations in genes can affect the way heart cells communicate, the strength of the heart muscle, and affect the heart rhythm condition resulting is fast, chaotic heartbeats. Identifying these genetic factors plays an important role in the disease prognosis, therapy and therefore outcome.
Informed Consent: Hereditary Assessment for Cardiac Conditions offered by **Advanced Testing in Clinical Genetics (ATCG)** focuses on identifying inherited cardiac conditions. It targets 174 genes with known associations to 17 inherited cardiac conditions including cardiomyopathy, arrhythmia, hypercholesterolemia, hypertriglyceridemia, and more. This assay is performed using genomic DNA isolated from a buccal swab. The test is intended for predictive genetic testing to determine the chances that a healthy individual with or without a family history of a cardiac condition might develop that disease. It is also performed as a pre-symptomatic genetic test to determine if an individual with a family history of cardiac disease, but no current symptoms, has the gene alterations associated with the disease. It is also intended for post-symptomatic genetic testing to identify the potential underlying cause of an existing cardiac disease. This test is a next-generation sequencing (NGS) used to provide comprehensive coverage of the genes associated with hereditary heart disease.
The patient has provided a signed Informed Consent for Genetic Testing based on our discussion of the personal and/or family history, the potential test results, and the implications for Medical Management. The patient is aware of the benefits, risks and limitations of the testing and has voluntarily agreed to the genetic test.

Conclusion
Knowledge of this patient's cardiac genetic information is important to accurately assess the patient's cardiac risks and will guide my recommendations for care. The value of genetic testing for these syndromes has been extensively documented in medical literature. In 2008, the American Heart Association, the American College of Cardiology, and the European Cardiac Society issued joint medical/scientific guidelines on the management of patients with ventricular arrhythmias and prevention of sudden cardiac death.
Thank you for your review and consideration. I hope you will support this request for genetic testing coverage for this patient. If you have any questions, or if I can be of further assistance, please do not hesitate to call: _____.

Sincerely,
Provider's Name: _____

Provider's Signature: _____ **Date: _____**

Advanced Testing in Clinical Genetics

Date: _____

Provider Practice Information

Practice Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Acknowledgement

I authorize ATCG to perform requested laboratory tests on my patients from my facility as directed on my signed orders at their primary site or any of their affiliated laboratories. I understand that it is my responsibility to determine the Medical Necessity of each / all test(s) requested. I certify that compliance with my patients / beneficiary's insurance(s) are in place, including records that reflect the need for the test(s) and document the order of the test(s). These records will be provided upon request. Further, I authorize and instruct ATCG to provide patient lab result report access online, sending account access to the listed practice contact. I understand that other delivery methods may be initiated by contacting ATCG. I understand that ATCG requisitions are to be submitted to ATCG only and that Bill Clinic invoices are to be paid on receipt.

First Name	Last Name	Title	NPI	Provider Signature