BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

TEST REVISION AUTHORIZATION FORM (TRAF)

IMPORTANT REMINDERS

For Add-on Test:

- If the ordering physician has changed, a new requisition form is required.
- The "Add-on Test" request must include a signature authorization from the party to be billed.
- If the patient sample was initially handled by your send-out department, this add-on request will need to originate from the same send-out department.
- If adding on Whole Exome Sequencing (WES) or Whole Genome Sequencing (WGS), the testing and reporting options must be completed below for all test participants.
- Baylor Genetics' Client Services team will contact you once the test is added. If you do not hear from us within 24 hours of submission of this form, please contact us at 1-800-411-GENE.

For Cancellation:

- Cancellation requests are processed only if acceptable cancellation documentation is received before 5:00 PM (CT) of the next business day from the day of sample receipt.
- Cancellation requests received after this time will not be accepted.

PATIENT INFORMATION & REQUEST

* REQUIRED FIELDS

Last Name * _____ First Name * _____ MI _____ Date of Birth (MM / DD / YYYY) * ____ / ____ / ____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Account # _____ Baylor Genetics Lab # _____ Family # _____ MR # _____

	TEST CODE*	TEST NAME*
◯ ADD-ON TEST ◯ CANCELLATION		
◯ ADD-ON TEST ◯ CANCELLATION		
◯ ADD-ON TEST ◯ CANCELLATION		

ADDITION INFORMATION:
*If sequential testing is requested, specify the testing sequence. Provide any relevant information that may be needed for the test revision, such as the accession number.

OPT-IN TESTING OPTIONS

WHOLE EXOME SEQUENCING & WHOLE GENOME SEQUENCING: If a box is not checked the lab will default to No / Not Report.

Option for Reporting of ACMG Secondary Findings
Variants in genes included in the ACMG secondary findings guidelines will be reported for each family member marked below. Each marked family member will receive their own report on these findings.

☐ Proband ☐ Mother ☐ Father ☐ Other Family Member

Last Name _____ First Name _____ Date of Birth (MM / DD / YYYY) * ____ / ____ / ____

Last Name _____ First Name _____ Date of Birth (MM / DD / YYYY) * ____ / ____ / ____

Last Name _____ First Name _____ Date of Birth (MM / DD / YYYY) * ____ / ____ / ____

Option for Reporting of Incidental Findings
Pathogenic and likely pathogenic variants in genes covered under Category II of the Incidental Findings section of the consent form will be reported.

☐ Please report pathogenic and likely pathogenic variants in genes associated with Incidental Findings.

Trio and Quad Orders with Both Parents Only – Option for Reporting of Research Findings
For variants in genes with no known disease association, these variants will be reported if biallelic or de novo.

☐ Please report biallelic and de novo variants in genes with no known disease association.

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CONTACT INFORMATION & SIGNATURE OF AUTHORIZATION (ALL FIELDS ARE REQUIRED TO PROCESS REQUEST)

POINT OF CONTACT:

Printed Name _____ Institution _____

Phone _____ Fax _____ Email _____

APPROVED BY:

Printed Name _____ Institution _____

Signature _____ ____ / ____ / ____
Date (MM / DD / YYYY)

BILLING INFORMATION

☐ Check here if billing information is the same as the original test request. If billing information is different, please fill out second page and submit with add-on request.

Note: Please notify your appropriate lab personnel if testing added is to be billed institutionally.

PAYMENT OPTIONS

IMPORTANT NOTICE

One of the three following billing options must be indicated below. Please forward all billing questions to: billing@baylorgenetics.com.

☐ **INSTITUTION**

Institution Name

Institution Code

Contact Name

Email (Required)

Billing Address Line 1

Billing Address Line 2

City

State Zip

Phone Fax

☐ **INSURANCE**

Provide A Legible Photocopy Of The Front & Back Of The Insurance Card Or HMO/Medicaid HMO Authorization/ Referral.

Please refer to the Financial Policy at www.baylorgenetics.com for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a client service 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 approved authorizations. Baylor Genetics cannot bill out-of-state welfare programs. We accept authorized Texas Medicaid HMO covered charges for genetic testing. Please contact our office prior to submitting a Texas Medicaid sample. Contact billing@baylorgenetics.com with questions.

Ordering Provider

ICD-10 Diagnosis Code(s) (Required)

◯ PPO, POS, Commercial Insurance
Provide complete member information with legible front & back photocopy of insurance card.

◯ HMO
Provide approved authorization #: _____
and attach legible front & back photocopy of insurance card.

◯ Texas Medicaid HMO
Provide approved authorization #: _____
and contact Billing at 1.800.411.4363.

☐ **SELF PAY** (PAYMENT MUST ACCOMPANY SAMPLE)

☐ CREDIT CARD (PLEASE SELECT ONE):

◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA

Valid Card #

____ / ____ Exp. Date (MM / YYYY) CVC Code

Cardholder Printed Name

Cardholder Signature

☐ CHECK/MONEY ORDER

Check/Money Order #

Amount Enclosed

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INSURED MEMBER'S INFORMATION

Last Name | First Name | MI | Date of Birth (MM / DD / YYYY) | Biological Sex

Policy # | Social Security # | Group #

Insurance Company Name | Insurance Company Phone

Insurance Company Address | City | State | Zip

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim.

I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I designate Baylor Genetics as my designated representative for purposes of appealing any denial of benefits by my insurance carrier. I irrevocably assign associated payment to Baylor Genetics, and direct that payment be made directly to Baylor Genetics. Please note, some payers may not cover certain screening tests.

If my health insurer does not cover the test or I do not have health insurance, I have received a good faith estimate of the cost for the genetic testing ordered by my provider and agree to pay for the cost of the genetic testing billed to me by Baylor Genetics based on that good faith estimate. More information is available in Baylor Genetics' No Surprises Act and Good Faith Estimate Notice located at www.baylorgenetics.com/no-surprises-act/. A Medicare Advance Beneficiary Notice (ABN) is required when Medicare criteria is not met.

Printed Name | Signature | Date (MM / DD / YYYY)