INVITAE

ORDER ONLINE at www.invitae.com/signin.

INVITAE CONFIRMATION CODE Place sticker with IB code here	ORDER ID For Invitae internal use only	Requisition Form FAMILY VARIANT TESTING/VUS RESOLUTION TRF920-2

PATIENT INFORMATION

First name	MI	Last name
Date of birth (MM/DD/YYYY)	Sex ◯ M ◯ F	MRN (medical record number)

Ancestry ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ Other:

Email address (for report access after release by medical professional)

Phone	Is this patient deceased? ◯ Yes ◯ No Deceased date:
Address	City
State / ZIP code / Country	

SPECIMEN INFORMATION

Label each tube with the patient's full name, date of birth, and specimen collection date.
A requisition form MUST accompany each specimen. www.invitae.com/specimen-requirements

Specimen type

◯ Blood ◯ Saliva ◯ Assisted saliva ◯ DNA - source:

We are unable to accept blood/saliva from patients with:

- *Allogeneic bone marrow transplants*
- *Blood transfusion <2 weeks prior to specimen collection*

Collection date (MM/DD/YYYY)	Special cases ◯ History of/current hematologic malignancy ◯ Resubmission

REASON FOR TESTING

ICD-10 codes	Previous results

Diagnostic for personal history? ◯ **Yes** ◯ **No** If yes, describe below.

Family history? ◯ **Yes** ◯ **No** If yes, describe in detail below or attach pedigree.

PRACTICE INFORMATION

Practice name and address

Institution/practice name	
Phone	Fax
Address	City
State / ZIP code / Country	

Primary clinical contact

Name	Role/title
Phone	NPI
Email address (for report access)	

Ordering physician

◯ **Same as primary clinical contact**

Name	NPI
Email address (for report access)	

Additional clinical or laboratory contact (optional)

Name	Email address (for report access)

Letter of Medical Necessity (LMN)

◯ I have attached an LMN and/or other documentation for insurance billing purposes.

◯ I agree to allow Invitae to transfer the information from this requisition to an LMN and/or other documentation using the ordering physician's name as the signature for insurance billing.

◯ INSURANCE BILLING (U.S. ONLY)

◯ **I have attached a copy of the patient's card**

Insurance company name	Member ID#
Patient relation to policy holder: ◯ Self	◯ Child ◯ Spouse ◯ Other Policy holder name

◯ PATIENT PAY BILLING

Invitae will send an electronic invoice to the patient email listed above

◯ INSTITUTIONAL BILLING

◯ **Send invoice to practice address above**

Billing contact name	Phone	Fax
Billing email address		
Billing address	City	
State / ZIP code / Country		

◯ OTHER BILLING

Invitae study code:

Invitae's family variant testing and VUS resolution program involves full analysis of the gene in which the original family member's variant was identified. For more information, visit www.invitae.com/family-testing.

Please attach the original proband's clinical report or provide Invitae RQ#

	INVITAE PROBAND RQ#	RELATIONSHIP TO PROBAND	GENE(S)*	VARIANT(S)
◯ **FAMILY VARIANT TESTING**				
◯ **VUS RESOLUTION**				

*If ordering a panel or additional gene(s) outside of the gene with a known familial variant, please use a standard requisition form

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing, and has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated). The Patient has further been informed and hereby authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer in order to process and/or appeal claims on behalf of the Patient. For amounts received directly, the Patient agrees to remit payment to Invitae for testing services rendered. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable state law to order this test.

Medical professional signature	Date

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