INVITAE

ORDER ONLINE at www.invitae.com/signin.

ORDER ID
For Invitae internal use only

INVITAE REQUISITION FORM

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 ○ French Canadian ○ Sephardic Jewish ○ Mediterranean ○ Other: _____

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

Address

City | State | ZIP code | Country

ORGANIZATION INFORMATION

Organization name and address

Organization name			Phone
Address			Fax
City	State	ZIP code	Country

Primary clinical contact

Name	NPI
Email address (for report access)	Phone

Ordering physician

○ **Same as primary clinical contact**

Name	NPI
Email address (for report access)	Phone

Additional clinical or laboratory contacts (optional)

Name	Email address (for report access)	Name	Email address (for report access)
Name	Email address (for report access)	Name	Email address (for report access)

○ INSURANCE BILLING (Please attach a copy of the patient's card.)

We do not accept insurance for certain tests *or* patients outside the US. Before completing this section, confirm your test is eligible at www.invitae.com/billing.

Primary insurance company name	Primary member ID#
Secondary insurance company name	Secondary member ID#
○ Patient has Medicare and was treated as a hospital inpatient (>24 hour stay) in the last 14 days.	Prior-authorization #

Letter of Medical Necessity (LMN)

○ I have attached an LMN and/or other documents 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.

○ INSTITUTIONAL BILLING

Invitae will send an invoice to the organization address above.
Please contact Invitae if this order should be billed to a different location.

○ PATIENT PAY BILLING

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

○ OTHER BILLING

Invitae partner code:

INVITAE

Patient's first name

Patient's last name

INVITAE DIAGNOSTIC REQUISITION FORM

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

Collection date (MM/DD/YYYY)

If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.

Specimen type

◯ Blood ◯ Saliva ◯ DNA - source: _____

DNA must be extracted in a CLIA or other suitably certified laboratory. We are unable to accept blood or saliva from patients with allogeneic bone marrow transplants or a blood transfusion <2 weeks prior to specimen collection.

Special cases

◯ History of/current hematologic malignancy

◯ Resubmission

Deceased date (MM/DD/YYYY)

Specimen ID (IB # found on tube) - optional:

Is this patient deceased? ◯ Yes ◯ No

REASON FOR TESTING

ICD-10 codes

Previous results

Primary indication:

ONCOLOGY

◯ Hereditary breast and ovarian cancer (HBOC) syndrome

◯ Lynch syndrome

◯ Polyposis (FAP)

◯ Other: _____

CARDIOLOGY

◯ Aortopathy

◯ Arrhythmia

◯ Cardiomyopathy

◯ Other: _____

OTHER

◯ Neurology

◯ Other: _____

Testing for a personal history of disease? ◯ Yes ◯ No If yes, describe below.

Age at diagnosis: _____

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

TEST SELECTION

This form supports three different ways of indicating test selection. Please select **one** of the three options below.

OPTION 1: SELECT AN INVITAE PANEL FROM OUR TEST CATALOG

Select your desired test(s) from the attached test catalog and discard any pages without a selection.

OPTION 2: INVITAE TEST CODE

Locate the test ID for the test you would like to order at www.invitae.com/tests or in our test catalog, and indicate the ID here.

Test code • **Add-on code (optional)**

OR

Invitae supports customization of your test. To create a custom panel, log in to your Invitae portal account or contact Client Services. Then indicate the ID associated with that panel here.

Custom panel ID

OPTION 3: FAMILY FOLLOW-UP TEST

Learn more about Invitae's family follow-up test options at www.invitae.com/family.

◯ **Family variant testing** ◯ **VUS resolution case #:** _____

Invitae proband RQ# _____

Relationship to proband _____

Gene(s) _____

Variant(s) _____

To request a complimentary specimen collection kit visit **www.invitae.com/request-a-kit**

SHIPPING INSTRUCTIONS

Please ship specimen overnight in insulated containers:

Attn: Invitae Client Services, 1400 16th Street, San Francisco, CA 94103, USA

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 (www.invitae.com/patient-consent), 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), and for orders originating outside the US, has been informed that the Patient's personal information and specimen will be transferred to and processed in the US. The Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer, if applicable, in order to process and/or appeal claims on behalf of the Patient. If a letter of medical necessity (LMN) has not been provided, the medical professional agrees to allow Invitae to transfer the information from this requisition to a LMN and/or other documentation using the medical professional's name as the signature for insurance billing. For amounts received directly, the Patient has agreed to remit payment to Invitae for testing services rendered. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. 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 law to order this test.

Medical professional signature

Date