CARDIOPULMONARY TEST REQUISITION FORM

PRECHECK HEALTH SERVICES, INC.
100 Biscayne Blvd., Suite 1611, Miami FL 33132
Phone: (305)-203-4711 — **CLIA:** 10D2210020
appointment@precheckhealth.com — www.precheckhealth.com

PATIENT INFORMATION

First name | MI | Last name | Date of birth (MM/DD/YYYY)

Biological sex
☐ Male
☐ Femal

MRN (medical record number)

Ethnicity
☐ Asian ☐Black/African American ☐ White/Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Other: _____

Email address (for billing contact and report access after clinician releases)

Mobile phone

Address

City | State/Prov | Zip/Postal code | Country

CLINICAL INFORMATION

Organization name			Phone	Fax
Address	City	State/Prov	ZIP/Postal Code	Country

CLINICAL TEAM

Primary clinical contact (contact for general inquires)

Name	NPI	Email address (for report access)

☐ INSURANCE BILLING (attach front and back of insurance card)

Attach clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays. We do not accept insurance for certain tests or patients outside the US.

Policyholder name	Patient relationship to ☐Self ☐Spouse ☐Child Other:			Medicare insurance billing only (select one):
Primary insurance company name	Primary member ID#	Primary insurance phone	Prior-authorization #	☐ Patient was treated as a hospital inpatient in the last 14 days
Secondary insurance company name	Secondary member ID#	Secondary insurance phone	Prior-authorization #	☐ Not a hospital patient

☐ PATIENT PAY BILLING

PreCheck Health Services, Inc. will send an electronic invoice to the patient email listed above. Insurance will not be billed.

☐ INSTITUTIONAL BILLING

Precheck Health Services, Inc. will send an invoice to the organization address above. Please contact us if this order should be billed to a different location.

☐ PARTNERSHIP PROGRAMS

PreCheck Health Services, Inc. partner code:

Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen.

SPECIMEN INFORMATION

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 ☑ Buccal Swab

DNA must be extracted in a CLIA or other suitable 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.

PreCheck Health Services Inc.

QUESTIONNAIRE

CLINICAL HISTORY

☐ No personal history of Cardiopulmonary disease

Sudden Lungs Failur ☐ Y ☐ N (if yes): # Episodes:..... Age first incident:..... .

History of Cardiopulmonary ☐ Y ☐ N Age at dx:.....

Type(s) of Cardiopulmnary:.....

History of Arrhythmia ☐ Y ☐ N

Age at dx:.....

Types (s) of Arrhythmia:. .....

☐ Family or personal history of chronic bronchitis?	☐ Yes ☐ No
☐ Pulmonaryedema?	☐ Yes ☐ No
☐ Family history of heart failure?	☐ Yes ☐ No
☐ Family or personal history of a COPD?	☐ Yes ☐ No
☐ cardiac arrhythmias?	☐ Yes ☐ No
☐ History of right-sided heart failure?	☐ Yes ☐ No
☐ Collection of fluid in legs or belly area?	☐ Yes ☐ No
☐ Diagnosed with Emphysema?	☐ Yes ☐ No
☐ Family history show the segregation of pulmonary emphysema?	☐ Yes ☐ No
☐ Diagnosed with alpha 1-antitrypsin deficiency-related pulmonary emphysema or early onset pulmonary emphysema?	☐ Yes ☐ No
☐ Diagnosed with cor pulmonale?	☐ Yes ☐ No

(CLINICAL INFORMATION & DETAILED MEDICAL RECORDS MUST BE ATTACHED)

Is this person affected: ○ Yes ○ No Clinical diagnos is_____

Reason for testing: ○ Diagnosis ○ Presymptomatic diagnosis Carrier/Familial Variant Testing

Please check all that apply. This is not a substitute for submitting clinical records.

Diagnosis
- ○ Amyloidosis
- ○ ARVC
- ○ Brugada syndrome
- ○ CPVT
- ○ DCM
- ○ Ehlers-Danlos syndrome
- ○ HCM
- ○ HHT
- ○ Hypertension
- ○ Loeys-Dietz syndrome
- ○ LQT syndrome
- ○ Noncompaction Cardiopulmonary (LVNC)
- ○ Marfan syndrome
- ○ PAH
- ○ RCM
- ○ SQT syndrome
- ○ Sudden Cardiac Arrest
- ○ Sudden Death

Echocardiogram
- ○ Aortic root dimensio _____
  - ○ Z-score: _____
- ○ EF%: _____
- ○ LVEDD _____
  - ○ Z-score: _____
- ○ Max LV wall thickness _____
- ○ Normal
- ○ Report Included

ECG
- ○ Prolonged QTc interval:
  - Max QTc: _____
- ○ Normal
- ○ Report Included

Arrhythmia/Cardiopulmonary
- ○ Abnormal atrioventricular conduction
- ○ Atrial fibrillation
- ○ Bradycardia
- ○ Fatty replacement of ventricular myocardial tissue
- ○ Heart transplant
- ○ Syncope
- ○ Torsades de pointe
- ○ Ventricular tachycardia

HHT
- ○ Arteriovenous malformation
- ○ Epistaxis
- ○ Telangiectasia

Dislipidemias
- ○ Atherosclerosis
- ○ Corneal Arcus
- ○ LDL-C level _____
- ○ Xanthomatosis

Marfan/TAAD/HDCT
- ○ Aortic/Arterial aneurysm
- ○ Aortic/Arterial dissection
- ○ Aortic root dilation
- ○ Arachnodactyly
- ○ Arterial tortuosity/ectasia
- ○ Arthralgia
- ○ Atypical scarring of skin
- ○ Beighton scor_____
- ○ Bifid uvula
- ○ Blue sclerae
- ○ Bruising susceptibility
- ○ Cleft lip
- ○ Cleft palate
- ○ Craniosynostosis
- ○ Cutis laxa
- ○ Dental crowding
- ○ Dural ectasia
- ○ Ectopia lentis
- ○ Flexion contracture
- ○ High palate
- ○ Hollow organ rupture:
  - ○ Uterine rupture ○ Intestinal perforation
  - ○ Other:_____
- ○ Hypertelorism
- ○ Joint contractures
- ○ Joint dislocations
- ○ Joint hypermobility
- ○ Meets Ghent criteria
- ○ Micrognathia / Retrognathia (circle what applies)
- ○ Midface retrusion
- ○ Mitral valve prolapse
- ○ Myopia
- ○ Osteoarthritis
- ○ Pectus carinatum
- ○ Pectus excavatum
- ○ Pes Planus
- ○ Pneumothorax
- ○ Recurrent fractures
- ○ Retinal detachment
- ○ Scoliosis/Kyphosis (circle what applies)
- ○ Skin findings, Specic
- ○ Stroke
- ○ Tall stature
- ○ Velvety skin

Abnormal heart morphology
- ○ Bicuspid aortic valve
- ○ Coarctation of aorta
- ○ Heart murmur
- ○ Heterotaxy
- ○ Hypoplastic left heart
- ○ Mitral valve prolapse
- ○ Patent ductus arteriosus
- ○ Patent foramen ovale
- ○ Tetralogy of Fallot
- ○ Ventricular septal defect
- ○ Atrial septal defect
- ○ Other:_____

PAH
- ○ Pulmonary hypertension

Cardiopulmonary
- ○ Chronic bronchitis
- ○ Chronic obstructive pulmonary disease (COPD)
- ○ Congestive heart failure
- ○ Emphysema

Other
- ○ Abnormality of the periventricular white matter
- ○ Angiokeratomas
- ○ Anhydrosis
- ○ Café-Au-Lait Macules
- ○ Hearing impairment:
  - ○ Sensorineural ○ Conductive
- ○ Craniosynostosis
- ○ Cystic hygroma
- ○ Downslanted palpebral fissures
- ○ Dysmorphic features:

Describe:_____

- ○ Elevated CPK
- ○ Hypotonia
- ○ Increase nuchal translucency
- ○ Intellectual disability
- ○ Keratoconus
- ○ Muscle weakness
- ○ Myopathy
- ○ Renal insufficiency
- ○ Short neck
- ○ Thromboembolism
- ○ Type:

COMPREHENSIVE CARDIOPULMONARY GENETIC TEST

Number of Genes: 232

Gene List ☒

ABCA3, ABCC8, ABCC9, ACADVL, ACTA2, ACTC1, ACTN2, ACVRL1, ADAMTS10, ADAMTS17, AGL, ALMS1, ALPK3, ANK2, AP3B1, ATP13A3, BAG3, BCOR, BGN, BLOC1S6, BMPR2, BRAF, CACNA1C, CACNA1D, CALM1, CALM2, CALM3, CASQ2, CAV1, CAV3, CBL, CCDC39, CCDC40, CCNO, CFAP298, CFAP300, CFTR, COL3A1, COX15, CPT1A, CPT2, CRELD1, CRYAB, CSF2RA, CSF2RB, CSRP3, DES, DKC1, DMD, DNAAF1, DNAAF2, DNAAF3, DNAAF4, DNAAF5, DNAAF19, DNAH5, DNAH9, DNAH11, DNAI1, DNAI2, DNAJC19, DNAL1, DOLK, DRC1, DRC2, DSC2, DSG2, DSP, EFEMP2, EIF2AK4, ELAC2, ELN, EMD, ENG, FAM111B, FBLN5, FBN1, FBN2, FHL1, FHOD3, FKRP, FLNA, FLNC, FOXF1, FOXJ1, GAA, GATA4, GATA6, GDF1, GDF2, GJA1, GJA5, GLA, GYG1, HCN4, HPS1, HPS3, HPS4, HPS5, HPS6, HRAS, HYDIN, JAG1, JPH2, JUP, KCNA5, KCND3, KCNE1, KCNH2, KCNJ2, KCNJ8, KCNK3, KCNQ1, KDR, KRAS, LAMA4, LAMP2, LDB3, LMNA, LOX, LTBP3, LTBP4, LZTR1, MAP2K1, MAP2K2, MED12, MED13L, MFAP5, MRPL3, MTO1, MYBPC3, MYH6, MYH7, MYH11, MYL2, MYL3, MYLK, MYPN, NDUFAF1, NDUFB11, NEXN, NHP2, NOP10, NOTCH1, NOTCH2, NPPA, NR2F2, NRAS, ODAD1, ODAD2, ODAD3, ODAD4, PARN, PKD1L1, PKP2, PLN, PLOD1, POT1, PRDM16, PRKAG2, PRKG1, PTPN11, RAF1, RBM20, RIT1, RSPH1, RSPH3, RSPH4A, RSPH9, RTEL1, RYR2, SCN1B, SCN2B, SCN5A, SDHA, SERPINA1, SFTPA1, SFTPA2, SFTPB, SFTPC, SGCD, SHOC2, SKI, SLC2A10, SLC7A7, SLC22A5, SLC25A20, SLC34A2, SMAD2, SMAD3, SMAD4, SMAD6, SMAD9, SMPD1, SOS1, SOS2, SOX17, SPEG, STING1, TAB2, TAFAZZIN, TBX1, TBX4, TBX5, TBX20, TCAP, TERC, TERT, TFAP2B, TGFB2, TGFB3, TGFBR1, TGFBR2, TINF2, TMEM43, TMEM70, TNNC1, TNNI3, TNNI3K, TNNT2, TPM1, TRDN, TRIM63, TRPM4, TTN, TTR, VCL, ZFPM2, ZIC3, NKX2-1, NKX2-5, NKX2-6

ICD-10 DX Code (s):

- ☐ C33 - Trachea
- ☐ C34.00 - Unspecified main bronchus
- ☐ C34.10 - Upper lobe unspecified bronchus or lung
- ☐ C34.11 - Malignant Neoplasm of upper lobe, right bronchus or lung
- ☐ C34.12 - Malignant Neoplasm of upper lobe, left bronchus or lung
- ☐ C34.2 - Malignant Neoplasm of Middle lobe, bronchus or lung
- ☐ C34.30 - Lower lobe bronchus or lung
- ☐ C34.31 - Malignant Neoplasm of lower lobe, right bronchus or lung
- ☐ C34.32 - Malignant Neoplasm of lower lobe, left bronchus or lung
- ☐ C34.33 - Malignant Neoplasm of lower lobe, bronchus or lung
- ☐ C34.80 - Overlapping sites of unspecified main bronchus or lung
- ☐ E84.0 - Cystic Fibrosis with pulmonary manifestations
- ☐ G47.33 - Obstructive sleep apnea (adult) (pediatric)
- ☐ I26.99 - Other pulmonary embolism without acute cor pulmonale
- ☐ I27.0 - Primary pulmonary hypertension
- ☐ I95.9 - Hypotension, unspecified
- ☐ J16.8 - Pneumonia due to other specified infectious organisms
- ☐ J18.9 - Pneumonia, unspecified organism
- ☐ J20.0 - Acute bronchitis due to Mycoplasma pneumoniae
- ☐ J20.1 - Acute bronchitis due to Hemophilus influenzae
- ☐ J20.2 - Acute bronchitis due to streptococcus
- ☐ J20.3 - Acute bronchitis due to coxsackievirus
- ☐ J20.4 - Acute bronchitis due to parainfluenza virus
- ☐ J20.5 - Acute bronchitis due to respiratory syncytial virus
- ☐ J20.6 - Acute bronchitis due to rhinovirus
- ☐ J20.7 - Acute bronchitis due to echovirus
- ☐ J20.8 - Acute bronchitis due to other specified organisms
- ☐ J20.9 - Acute bronchitis unspecified
- ☐ J20.9 - Acute bronchitis, unspecified
- ☐ J28.0 - Acute pulmonary Edema
- ☐ J40 - Bronchitis, not specified as acute or chronic
- ☐ J44.1 - Obstructive chronic bronchitis, with (acute) exacerbation
- ☐ J44.9 - Obstructive chronic bronchitis, without (acute) exacerbation
- ☐ J45.20 - Mild Intermittent Asthma
- ☐ J45.21 - Mild Intermittent Asthma with status asthmaticus
- ☐ J45.22 - Mild Intermittent Asthma with acute exacerbation
- ☐ J45.30 - Mild Persistent Asthma
- ☐ J45.31 - Mild Persistent Asthma with status asthmaticus
- ☐ J45.32 - Mild Persistent Asthma with acute exacerbation
- ☐ J45.40 - Moderate persistent Asthma
- ☐ J45.41 - Moderate persistent Asthma with status asthmaticus
- ☐ J45.42 - Moderate persistent Asthma with acute exacerbation
- ☐ J45.50 - Severe persistent Asthma
- ☐ J45.51 - Severe persistent Asthma with status asthmaticus
- ☐ J45.52 - Severe persistent Asthma with acute exacerbation
- ☐ J45.909 - Unspecified asthma, uncomplicated
- ☐ J81.0 - Acute pulmonary edema
- ☐ J90 - Pleural effusion, not elsewhere classified
- ☐ J95.4 - Transfusion related acute lung injury (TRALI)
- ☐ J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.01 - Acute respiratory failure with hypoxia
- ☐ J96.02 - Acute respiratory failure with hypercapnia
- ☐ J96.10 - Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.11 - Chronic respiratory failure with hypoxia
- ☐ J96.12 - Chronic respiratory failure with hypercapnia
- ☐ J96.20 - Acute/Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.21 - Acute/Chronic respiratory failure with hypoxia
- ☐ J96.22 - Acute/Chronic respiratory failure with hypercapnia
- ☐ J98.11 - Atelectasis
- ☐ J98.12 - Other pulmonary collapse
- ☐ J98.3 - Interstitial emphysema
- ☐ J98.4 - Other disorders of lung
- ☐ N17.9 - Acute kidney failure, unspecified
- ☐ R05 - Cough
- ☐ R06.02 - Shortness of Breath
- ☐ R06.02 - Shortness of breath
- ☐ R06.2 - Wheezing
- ☐ R07.1 - Chest pain on breathing
- ☐ R07.81 - Pleurodynia
- ☐ R09.02 - Hypoxemia
- ☐ R09.89 - Other specified symptoms and signs involving the circulatory and respiratory systems
- ☐ R22.2 - Localized swelling, mass and lump, trunk (chest mass)
- ☐ R22.2 - Localized swelling, mass and lump, trunk (chest mass) (localized swelling of chest)
- ☐ R65.20 - Severe sepsis without septic shock
- ☐ R91.1 - Solitary pulmonary nodule
- ☐ R91.8 - Other nonspecific abnormal finding of lung field (lung mass)
- ☐ R94.2 - Abnormal results of pulmonary function studies
- ☐ Z79.01 - Long-term (current) use of anticoagulants
- ☐ Z85.118 - Personal history of malignant neoplasm of bronchus and lung

ADDITIONAL ICD CODES

_____

_____

_____

This list is intended to be used as a reference to assist ordering Physicians in providing ICD-10 Diagnosis Codes as required by Medicare and other insurers to determine the medical necessity of testing being ordered. This is not an exhaustive list of all applicable diagnoses. Physicians are not required to use these codes but should report the diagnostic codes that best describes the reason for performing the test based on individual patient diagnoses. It is the Physician's Responsibility to determine both the medical need for and the utilization of, all health care services ordered.

Patient Informed Consent for Genetic Testing

I, _____The Patient authorize PreCheck Health Services, Inc., to conduct genetic testing for CARDIOPULMONARY GENETIC TEST (Disease and/or Test Name), as ordered by my physician or authorized healthcare provider or my child's or dependent's physician or autho-rized healthcare provider, and authorize the collection of a sample for the purpose of that testing.

I acknowledge and consent to the following:

1. My physician or his/her designee (such as a genetic counselor) has fully covered the following:
(A) purpose, description and nature of the test and its potential uses;
(B) reliability of positive or negative results and the level of certainty that a positive test result for the disease or condition serves as a predictor of such disease, the effectiveness and limitations of the genetic test and the meaning of the genetic test results;
(C) implications of taking the genetic test, including the medical risks and benefit;
(D) description of the disease or condition tested for;
(E) the availability and importance of genetic counseling. I acknowledge that I have been provided with information identifying a genetic counselor or medical geneticist from whom I might obtain such counseling and understand that I may seek counseling prior to signing this consent; and
(F) a positive test result is an indication that I may be predisposed to or have the specific disease or condition tested for and I understand that I may wish to consider further independent testing, consult with my physician or pursue genetic counseling to discuss the test results.

2. I authorize and I understand that I will receive the test results from my physician unless I direct otherwise. I understand that I have a right to confidential treatment of my sample and results and that my test results will only be disclosed as authorized in this consent.

3. Test results will be retained in accordance with applicable laws. I understand that only my physician's office and/or PreCheck Health Services, Inc. will have access to my sample and that my sample will be used only for the purposes for which I have given my consent.

Patient's Statement

I, the undersigned, have been informed about the test(s) purpose, procedures, possible beneÿts and risks, and I have received a copy of this consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to genetic testing.

PATIENT SIGNATURE*	SIGNATURE OF AUTHORIZED REPRESENTATIVE
PRINT NAME*	PRINT NAME
DATE*	DATE

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 PreCheck Health Services Inc. (PCHS) Informed Consent for Genetic Testing. For orders originating outside the US, the Patient has been informed their personal information and specimen will be transferred to and processed in the US. The Patient has been informed that PCHS may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional). If insurance billing is selected, the Patient has been informed and authorizes PCHS and its designed to release information concerning testing to their insurer. The medical professional agrees to allow PCHS (1) to transfer the information from this TRF to a letter of medical necessity and/or other documentation using the medical professional's name as the signature as well as (2) assist the patient in obtaining pre-test genetic counseling from a third-party service, as required by the patient's insurance provider. I acknowledge that the Patient has agreed that if the Patient's insurer does not reimburse PCHS in full for any reason then PCHS may bill the Patient for the services and the Patient will remit payment to PCHS For amounts the Patient receives from the insurer, the Patient has agreed to remit payment to PCHS for services rendered. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. I attest that I am authorized under applicable law to order this test.

ORDERING PHYSICIAN SIGNATURE*	DATE: (MM/DD/YYYY)

PRECHECK HEALTH SERVICES, INC.
100 Biscayne Blvd., Suite 1611, Miami FL 33132
Phone: (305)-203-4711 **CLIA:** 10D2210020

Patient Name: _____, Patient ID Number: _____
Notifier: PreCheck Health Services

Advance Beneficiary Notice of Non-Coverage (ABN) — All Insurance Providers

Notice to Patients: Your health insurance plan, whether Medicare or a commercial provider, may not cover all tests or services — including those that you and your healthcare provider consider medically necessary. This notice informs you that one or more of the following PreCheck Health tests may not be covered, and you may be financially responsible.

Tests That May Not Be Covered:

Test Category	Examples	Reason for non-coverage	Estimated Cost
PharmacoCheck+	Pharmacogenetic testing	Not deemed medically necessary for your diagnosis	Up to $295
Germline Custom Panels	ImmunoCheck+, CancerCheck+ NeuroCheck+, MetabolicCheck+ ThyroidCheck+, etc.…	Insurance exclusions, medical necessity, etc.	Up to $295

What You Need to Do:

1. Review this notice carefully to make an informed decision.
2. Ask any questions you may have before proceeding.
3. Select one of the options below to indicate your decision.

Note: If you select Option 1 or 2, we may attempt to coordinate with other insurance carriers you have. However, we are not required to do so by Medicare or other insurers.

Patient Options: (Please select only one option)

☐ Option 1: I want to receive the PreCheck Health Test(s) listed above. I understand that my insurance provider may not cover these services. I would like a claim submitted to my insurer for an official coverage decision. If denied, I agree to be responsible for payment. I understand that I may appeal the denial in accordance with my insurer's policies.

☐ Option 2: I want to receive the PreCheck Health Test(s) listed above. I do not want a claim submitted to my insurer. I agree to pay out of pocket and understand that I waive my right to an appeal through my insurance plan.

☐ Option 3: I do not want to receive the PreCheck Health Test(s) listed above. I understand that I will not be billed for the service and cannot appeal a non-coverage decision.

Additional Information:

-If you choose Option 1, PreCheck Health Services will attempt to contact you to discuss your eligibility for financial assistance and may provide you with the option to cancel your order before testing begins. If you have questions about your financial responsibility or coverage, please contact us at ***(305) 203-4711.***
-This form serves as a courtesy and does not represent an official decision by your insurance provider. If you have questions about your insurance policy or billing, contact your provider directly.
-For Medicare-specific questions, call ***1-800-MEDICARE*** (1-800-633-4227 / TTY: 1-877-486-2048).

Patient Acknowledgment:

By signing below, you confirm that you have received, reviewed, and understood this notice. You will also be provided with a copy for your records.

Signature of Patient or Authorized Representative: _____. Date: _____/_____/_____.