COMPREHENSIVE NEUROLOGY 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: _____

Primary insurance company name | Primary member ID# | Primary insurance phone | Prior-authorization #

Secondary insurance company name | Secondary member ID# | Secondary insurance phone | Prior-authorization #

Medicare insurance billing only (select one):
☐ Patient was treated as a hospital inpatient in the last 14 days
☐ 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.

COMPREHENSIVE NEUROLOGY TESTING

For individuals that meet the eligibility criteria below and wish to receive the program specific genetic testing panels.

REQUIRED: You must select below the appropriate eligibility criteria for this patient.

This program is available to individuals 18 or older suspected of or at risk of having a Comprehensive Neurology disorder based on one or more of the following (please select all that apply)*:

Symptomatic individual with clinical diagnosis or suspicion of one of the following (check one):

- ☐ Amyotrophic Lateral Sclerosis Panel
- ☐ Ataxia Panel
- ☐ Autism Spectrum Disorders Panel
- ☐ Cerebral Cavernous Malformation Panel
- ☐ Charcot-Marie-Tooth Neuropathy Panel
- ☐ Coenzyme q10 Deficiency Panel
- ☐ Collagen Type VI-Related Disorders Panel
- ☐ Comprehensive Epilepsy Panel
- ☐ Comprehensive Muscular Dystrophy / Myopathy Panel
- ☐ Congenital Myasthenic Syndromes Panel
- ☐ Creatine Metabolism Deficiency Panel
- ☐ Dementia Panel
- ☐ Dystonia Panel
- ☐ Emery-Dreifuss Muscular Dystrophy Panel
- ☐ Epileptic Encephalopathy Panel
- ☐ Holoprosencephaly Panel
- ☐ Idiopathic Generalized and Focal Epilepsy Panel
- ☐ Leukodystrophy and Leukoencephalopathy Panel
- ☐ LGMD and Congenital Muscular Dystrophy Panel

Asymptomatic individual with family history of early (<65 years of age) onset diagnosis of one of the following conditions (check one):

- ☐ Lissencephaly Panel
- ☐ Macrocephaly / Overgrowth Syndrome Panel
- ☐ Metabolic Epilepsy Panel
- ☐ Metabolic Myopathy and Rhabdomyolysis Panel
- ☐ Microcephaly and Pontocerebellar Hypoplasia Panel
- ☐ Migraine Panel
- ☐ NCL and Progressive Myoclonic Epilepsy Panel
- ☐ Nemaline Myopathy Panel
- ☐ Neuro-Ophthalmology Panel
- ☐ Neuronal Migration Disorder Panel
- ☐ Parkinson Disease Panel
- ☐ Periodic Paralysis Panel
- ☐ Polymicrogyria Panel
- ☐ Porphyria Panel
- ☐ Septo-Optic Dysplasia Panel
- ☐ Spastic Paraplegia Panel
- ☐ Spinal Muscular Atrophy Panel
- ☐ Tuberous Sclerosis Panel
- ☐ X-linked Intellectual Disability Panel

Family member with known disease-causing variant in one of the genes included on the Combined Hereditary Dementia and Amyotrophic Lateral Sclerosis Panel OR Hereditary Parkinson's Disease and Parkinsonism Panel (list gene): _____

CLINICAL HISTORY (it is strongly encouraged to include notes, reports and/or previous genetic test results for this individual or

Cognitive Features	YES	NO	UNKNOWN
Progressive cognitive decline - amnestic presentation (memory loss, impairment in learning and recall)	☐	☐	☐
Progressive cognitive decline - language presentation (word-finding deficits)	☐	☐	☐
Progressive cognitive decline - visuospatial presentation (spatial cognition-object agnosia, facial recognition, simultagnosia and alexia)	☐	☐	☐
Progressive cognitive decline - executive dysfunction (impaired reasoning, judgment and problem solving)	☐	☐	☐
Behavioral changes (disinhibition/ impulsivity, apathy/inertia, and/or loss of sympathy/empathy)	☐	☐	☐
Behavioral changes (perseverative/compulsive behaviors and/or hyperorality)	☐	☐	☐
Psychiatric illness (psychosis, mania, hallucinations, delusions, etc.)	☐	☐	☐
Other: _____	☐	☐	☐
Motor Features			
Cerebellar ataxia (gait and/or limb ataxia)	☐	☐	☐
Oculomotor dysfunction (ex: oculomotor apraxia, strabismus, and/or nystagmus)	☐	☐	☐
Increased muscle tone and/or increased extremity deep-tendon reflexes/ hyperreflexia (jaw jerk, Hoffman sign, positive Babinski sign, crossed adductors, extensor plantor response)	☐	☐	☐
Spasticity	☐	☐	☐
Pseudobulbar affect (inappropriate laughing/crying/forced yawning)	☐	☐	☐

Motor Features (continued)	YES	NO	UNKNOWN
Progressive muscle weakness and/or atrophy	☐	☐	☐
Muscle fasciculations and/or cramps	☐	☐	☐
Hyporeflexia and/or decreased or absent deep tendon reflexes	☐	☐	☐
Parkinsonism (bradykinesia, postural instability, rigidity, facial masking, resting tremor)	☐	☐	☐
Tardive dyskinesia (irregular, jerky movements), dystonia (patterned/ twisting movements and postures) and/or myoclonus (muscle jerks)	☐	☐	☐
Dysarthria (difficulty speaking)	☐	☐	☐
Dysphagia (swallowing difficulties)	☐	☐	☐

Neuroimaging, biomarkers, genetic and/or neuropathophysiology findings

- ☐ Abnormal MRI
  Major finding(s)? _____
- ☐ Abnormal PET scan or CSF analysis
  Major finding(s)? _____
- ☐ Abnormal brain pathology findings (typically only available post-mortem)
  Major finding(s)? _____
- ☐ Abnormal EMG
  Major finding(s)? _____
- ☐ Previously tested for C9orf72 gene at outside laboratory?
  Test result (positive, negative, intermediate) _____
  [please include copy of previous test result if available]

Other features

- ☐ Paget disease of bone
- ☐ Supranuclear palsy
- ☐ Autonomic dysfunction (ex: orthostatic hypotension, urinary incontinence)
- ☐ Familial insomnia
- ☐ Other relevant clinical features: _____

COMPREHENSIVE NEUROLOGY

Genes# - 203

AARS2, ABCD1, ACADM, ADCY5, AFG3L2, AIFM1, ALDH7A1, ANG, ANO10, ANXA11, APOE, APP, APTX, ARSA, ATL1, ATP13A2, ATP1A2, ATP1A3, ATP7B, BCKDHA, BCKDHB, BCS1L, BSCL2, C19ORF12, C21ORF2, CACNA1A, CAPN1, CDKL5, CHCHD10, CHD2, CHMP2B, COASY, COL4A1, COL4A2, COQ2, COQ8A, COX10, CP, CSF1R, CST3, CTSF, CYP7B1, DCTN1, DDHD1, DDHD2, DGUOK, DHCR7, DNA2, DNAJB2, DNAJC5, DNAJC6, DNM2, DNMT1, DYNC1H1, EGR2, ELP1, ERLIN2, FANCC, FBXO7, FGF14, FIG4, FTL, FUS, G6PC, GAA, GABRG2, GALC, GALT, GBA, GBE1, GCH1, GDAP1, GFAP, GJB1, GLA, GNAL, GNB4, GRID2, GRIN2A, GRN, GSN, HBB, HEPACAM, HEXA, HINT1, HNRNPA1, HNRNPA2B1, HSPB1, HSPB8, HTRA1, INF2, ITPR1, KCNA1, KCNC3, KCNQ2, KIF5A, LITAF, LMNB1, LRRK2, MAPT, MATR3, MCOLN1, MECP2, MFN2, MGME1, MME, MPV17, MPZ, NEFL, NEK1, NIPA1, NOTCH3, NPC1, NPC2, OPA1, OPA3, OPTN, PAH, PANK2, PARK7, PCDH19, PDGFB, PDSS2, PFN1, PINK1, PLA2G6, PLP1, PMP22, PNKD, PNPLA6, POLG, POLG2, PRKCG, PRKRA, PRNP, PRPS1, PRRT2, PRX, PSEN1, PSEN2, RAB39B, REEP1, RRM2B, SACS, SCN1A, SCN1B, SCN2A, SCN8A, SCO1, SCO2, SETX, SGCE, SH3TC2, SLC25A4, SLC2A1, SLC52A2, SLC52A3, SLC9A6, SMPD1, SNCA, SOD1, SORD, SPAST, SPG11, SPG7, SPTBN2, SPTLC1, SPTLC2, SQSTM1, SSBP1, STUB1, STXBP1, SUCLA2, SUCLG1, SYNGAP1, SYNJ1, TAFAZZIN, TARDBP, TBK1, TCF4, TH, THAP1, TK2, TOR1A, TPP1, TREM2, TREX1, TRPV4, TSC1, TSC2, TTBK2, TTR, TUBA4A, TWNK, TYMP, UBQLN2, VAPB, VCP, VPS35, WASHC5, WDR45, ZEB2, ZFYVE26

INDICATION (S) FOR TESTING — ICD-10 Codes

Inflammatory diseases of the central nervous system (G00-G09)
- ☐ Bacterial meningitis, not elsewhere classified (G00)
- ☐ Meningitis in bacterial diseases classified elsewhere (G01)
- ☐ Meningitis in oth infec/parastc diseases classd elswhr (G02)
- ☐ Meningitis due to other and unspecified causes (G03)
- ☐ Encephalitis, myelitis and encephalomyelitis (G04)
- ☐ Encphlts, myelitis & encephalomyelitis in dis classd elswhr (G05)
- ☐ Intracranial and intraspinal abscess and granuloma (G06)
- ☐ Intcrn & intraspinal abscs & granuloma in dis classd elswhr (G07)
- ☐ Intracranial and intraspinal phlebitis and thrombophlebitis (G08)
- ☐ Sequelae of inflammatory diseases of central nervous system (G09)

Systemic atrophies primarily affecting the central nervous system (G10-G14)
- ☐ Huntington's disease (G10)
- ☐ Hereditary ataxia (G11)
- ☐ Spinal muscular atrophy and related syndromes (G12)
- ☐ Systemic atrophies aff cnsl in diseases classd elswhr (G13)
- ☐ Postpolio syndrome (G14)

Extrapyramidal and movement disorders (G20-G26)
- ☐ Parkinson's disease (G20)
- ☐ Secondary parkinsonism (G21)
- ☐ Other degenerative diseases of basal ganglia (G23)
- ☐ Dystonia (G24)
- ☐ Other extrapyramidal and movement disorders (G25)
- ☐ Extrapyramidal and movement disord in diseases classd elswhr (G26)

Other degenerative diseases of the nervous system (G30-G32)
- ☐ Alzheimer's disease (G30)
- ☐ Oth degenerative diseases of nervous system, NEC (G31)
- ☐ Oth degeneratv disord of nervous sys in dis classd elswhr (G32)

Demyelinating diseases of the central nervous system (G35-G37)
- ☐ Multiple sclerosis (G35)
- ☐ Other acute disseminated demyelination (G36)
- ☐ Other demyelinating diseases of central nervous system (G37)

Episodic and paroxysmal disorders (G40-G47)
- ☐ Epilepsy and recurrent seizures (G40)
- ☐ Migraine (G43)
- ☐ Other headache syndromes (G44)
- ☐ Transient cerebral ischemic attacks and related syndromes (G45)
- ☐ Vascular syndromes of brain in cerebrovascular diseases (G46)
- ☐ Sleep disorders (G47)

Nerve, nerve root and plexus disorders (G50-G59)
- ☐ Disorders of trigeminal nerve (G50)
- ☐ Facial nerve disorders (G51)
- ☐ Disorders of other cranial nerves (G52)
- ☐ Cranial nerve disorders in diseases classified elsewhere (G53)
- ☐ Nerve root and plexus disorders (G54)
- ☐ Nerve root and plexus compressions in diseases classd elswhr (G55)
- ☐ Mononeuropathies of upper limb (G56)
- ☐ Mononeuropathies of lower limb (G57)
- ☐ Other mononeuropathies (G58)
- ☐ Mononeuropathy in diseases classified elsewhere (G59)

Polyneuropathies and other disorders of the peripheral nervous system (G60-G65)
- ☐ Hereditary and idiopathic neuropathy (G60)
- ☐ Inflammatory polyneuropathy (G61)
- ☐ Other and unspecified polyneuropathies (G62)
- ☐ Polyneuropathy in diseases classified elsewhere (G63)
- ☐ Other disorders of peripheral nervous system (G64)
- ☐ Sequelae of inflammatory and toxic polyneuropathies (G65)

Diseases of myoneural junction and muscle (G70-G73)
- ☐ Myasthenia gravis and other myoneural disorders (G70)
- ☐ Primary disorders of muscles (G71)
- ☐ Other and unspecified myopathies (G72)
- ☐ Disord of myoneural junction and muscle in dis classd elswhr (G73)
- ☐ Cerebral palsy and other paralytic syndromes (G80-G83)
- ☐ Cerebral palsy (G80)
- ☐ Hemiplegia and hemiparesis (G81)
- ☐ Paraplegia (paraparesis) and quadriplegia (quadriparesis) (G82)
- ☐ Other paralytic syndromes (G83)

Other disorders of the nervous system (G89-G99)
- ☐ Pain, not elsewhere classified (G89)
- ☐ Disorders of autonomic nervous system (G90)
- ☐ Hydrocephalus (G91)
- ☐ Toxic encephalopathy (G92)
- ☐ Other disorders of brain (G93)
- ☐ Other disorders of brain in diseases classified elsewhere (G94)
- ☐ Other and unspecified diseases of spinal cord (G95)
- ☐ Other disorders of central nervous system (G96)
- ☐ Intraop and postproc comp and disorders of nervous sys, NEC (G97)
- ☐ Other disorders of nervous system not elsewhere classified (G98)
- ☐ Oth disorders of nervous system in diseases classd elswhr (G99)

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 NEURO 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)

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: _____/_____/_____.