

PATIENT INFORMATION			
First name	MI	Last name	Date of birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Biological sex	MRN (medical record number)	Ethnicity	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____	
Email address (for billing contact and report access after clinician releases)		Mobile phone	
<input type="text"/>		<input type="text"/>	
Address			
<input type="text"/>			
City	State/Prov	Zip/Postal code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CLINICAL INFORMATION				
Organization name	Phone		Fax	
Address		City	State/Prov	ZIP/Postal Code
				Country
CLINICAL TEAM				
Primary clinical contact (contact for general inquiries)				
Name	NPI	Email address (for report access)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

<input type="checkbox"/> 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 <u>do not</u> accept insurance for certain tests or patients outside the US.				
Policyholder name	Patient relationship to			Medicare insurance billing only (select one):
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Other: _____			<input type="checkbox"/> Patient was treated as a hospital inpatient in the last 14 days
Primary insurance company name	Primary member ID#	Primary insurance phone	Prior-authorization #	<input type="checkbox"/> Not a hospital patient
Secondary insurance company name	Secondary member ID#	Secondary insurance phone	Prior-authorization #	
<input type="checkbox"/> PATIENT PAY BILLING		<input type="checkbox"/> INSTITUTIONAL BILLING		<input type="checkbox"/> PARTNERSHIP PROGRAMS
PreCheck Health Services, Inc. will send an electronic invoice to the patient email listed above. Insurance will not be billed.		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.		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)	Specimen type
<input type="text"/>	<input type="checkbox"/> Blood <input checked="" type="checkbox"/> Buccal Swab
If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.	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.

Custom Hereditary Cancer Genes (116)

AIP, ALK, ANKRD26, APC, ATM, ATR, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, BUB1B, CDC73, CDH1, CDK4, CDKN1B, CDKN1C, CDKN2A, CEBPA, CHEK2, CTNNA1, CYLD, DDB2, DICER1, DIS3L2, DKC1, ELANE, EPCAM, ERCC2, ERCC3, ERCC4, ERCC5, EXT1, EXT2, FAN1, FANCM, FH, FLCN, GATA2, GPC3, GREM1, HOXB13, HRAS, IKZF1, KIT, LZTR1, MAX, MBD4, MEN1, MET, MITF, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NHP2, NOP10, NTHL1, PALB2, PAX5, PDGFRA, PHOX2B, PIK3CA, PMS2, POLD1, POLE, POLH, POT1, PRKAR1A, PRSS1, PTCH1, PTCH2, PTEN, RAD51C, RAD51D, RB1, RECQL4, REST, RET, RHBDF2, RUNX1, SBD5, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SRP72, STK11, SUFU, TERC, TERT, TINF2, TMEM127, TP53, TRIP13, TSC1, TSC2, VHL, WRAP53, WRN, WT1, XPA, XPC

HEREDITARY CANCER TEST REQUISITION (BLUE SECTIONS REQUIRED)

INDICATIONS FOR TESTING (Check all that apply)

☐ Diagnostic

☐ Family history

☐ Positive or normal control

☐ Other.....

ICD-10 code(s):.....

Will Patient management be changed depending on the test results?☐ Yes ☐ No STAT TEST : Date results needed (if Known):

PATIENT CLINICAL HISTORY ☐ No Personal History Of Cancer

Cancer /Tumer	Age at DX	Pathology and Other info
Breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk
2nd primary breast		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk
Ovarian		Fallopian tube Primary peritoneal
Prostate		Gleason score:
Hematologic		Type: Allogeneic bone marrow or peripheral stem cell transport
Other Cancer		Type:
Other clinical history:		

PERSONAL HISTORY

Is/was this patient affected or symptomatic[†]?

☐ Yes

☐ No

If yes, describe below and attach clinical notes. Age at diagnosis: _____

[†] Symptomatic means the patient has features or signs known or suspected to be related to the genetic testing being ordered and could include findings on physical examination, laboratory tests, or imaging.

Has this patient had genetic testing before?

☐ Yes

☐ No

If yes, write test results and attach the report.

FAMILY HISTORY

Is there a family history of disease for which the patient is being tested? ☐ Yes ☐ No

If yes, describe below and attach pedigree and/or clinical notes.

Relationship to patient	Maternal or paternal	Diagnosed condition	Age at diagnosis

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.

HEREDITARY CANCER PATIENT QUESTIONNAIRE

Please read and answer the questions below. While answering, consider relatives who are living along with those who have passed away who are sick and those in remission, male and female relatives, and relatives on both your mother and father’s side of the family. “Relatives” refer to blood relatives and include mother, father, son, daughter, brother, sister, half-brother, half-sister, uncle, aunt, nephew, niece, grandparent, grandchild, cousin.

1. Have You ever been diagnosed with any these cancers prior to the age listed?

- ☐ BREAST CANCER (age 45 or younger)
- ☐ COLON CANCER (age 50 or younger)
- ☐ ENDOMETRIAL/UTERINE CANCER (age 50 or younger)
- ☐ OVARIAN CANCER (any age)

2. Have you ever been diagnosed with either PROSTATE or PANCREATIC cancer? ☐ YES ☐ NO IF

YES: Do you also have ONE or more relatives diagnosed with any of these cancers?

- ☐ PROSTATE CANCER ☐ PANCREATIC CANCER ☐ BREAST CANCER (age 50 or Younger)

3. Have YOU ever been diagnosed with BREAST cancer between ages 46-50? ☐ YES ☐ NO

IF YES: Do you also have any of following?

- ☐ ONE or more relatives diagnosed with BREAST CANCER, PRANCREATIC CANCER or PROSTATE CANCER (at ANY AGE)
- ☐ TWO or more relatives on the same side of the family diagnosed with BREAST CANCER AT ANY AGE?

4. Have YOU been diagnosed with BREAST cancer at any age? ☐ YES ☐ NO

IF YES: DO you also have any of the following?

- ☐ ONE or relatives diagnosed with BREAST CANCER at age 50 or under?
- ☐ TWO or more relatives on the same side of the family diagnosed with BREAST CANCER at ANY AGE?

5. Have any relatives been diagnosed with BREAST (age 45 and under) or OVARIAN CANCER (any age)? ☐ YES ☐ NO

6. Do you have ONE relative that was diagnosed with BREAST cancer (any age)? ☐ YES ☐ NO

IF YES: Do you also have any of the following on the same side of the family?

- ☐ ONE or more additional relatives diagnosed with BREAST CANCER at age 50 or younger
- ☐ TWO or more relatives diagnosed with BREAST CANCER at ANY AGE?

7. DO you have ONE relative that was diagnosed with PANCREATIC OR PROSTATE cancer? ☐ YES ☐ NO

IF YOU: Do you also have ONE or more additional relatives on the same side of your family diagnosed with any of these cancers?

- ☐ PROSTATE CANCER
- ☐ PANCREATIC CANCER
- ☐ BREAST CANCER (age 50 or younger)

8. Do you have ONE Relative that was diagnosed with COLORECTAL or ENDOMETRICAL cancer? ☐ YES ☐ NO

IF YES:

- ☐ Do you also have ONE or more additional relatives on the same side of family diagnosed at age 50 or younger with any of these cancers: COLORECTAL or ENDOMETRIAL
- ☐ Do you have TWO or more additional relatives on the same side of your family diagnosed with any of these Cancers at any age? COLORECTAL, ENDOMETRICAL, PANCREATIC, SMALL BOWEL, HEPATOBILIARY TRACT, LIVER, URINARY TRACT, RENAL PELVIS, URETER, OVARIAN, BRAIN or STOMACH

ICD-10 DX Code (s):

Group 1

<input type="checkbox"/> C16.0 - Malignant neoplasm of cardia <input type="checkbox"/> C16.1 - Malignant neoplasm of fundus of stomach <input type="checkbox"/> C16.2 - Malignant neoplasm of body of stomach <input type="checkbox"/> C16.3 - Malignant neoplasm of pyloric antrum <input type="checkbox"/> C16.4 - Malignant neoplasm of pylorus <input type="checkbox"/> C16.5 - Malignant neoplasm of lesser curvature of stomach, unspecified <input type="checkbox"/> C16.6 - Malignant neoplasm of greater curvature of stomach, unspecified <input type="checkbox"/> C16.8 - Malignant neoplasm of overlapping sites of stomach <input type="checkbox"/> C16.9 - Malignant neoplasm of stomach, unspecified <input type="checkbox"/> C17.0 - Malignant neoplasm of duodenum <input type="checkbox"/> C17.1 - Malignant neoplasm of jejunum <input type="checkbox"/> C17.2 - Malignant neoplasm of ileum <input type="checkbox"/> C17.3 - Meckel's diverticulum, malignant <input type="checkbox"/> C17.8 - Malignant neoplasm of overlapping sites of small intestine <input type="checkbox"/> C17.9 - Malignant neoplasm of small intestine, unspecified <input type="checkbox"/> C18.0 - Malignant neoplasm of cecum <input type="checkbox"/> C18.1 - Malignant neoplasm of appendix <input type="checkbox"/> C18.2 - Malignant neoplasm of ascending colon <input type="checkbox"/> C18.3 - Malignant neoplasm of hepatic flexure <input type="checkbox"/> C18.4 - Malignant neoplasm of transverse colon <input type="checkbox"/> C18.5 - Malignant neoplasm of splenic flexure <input type="checkbox"/> C18.6 - Malignant neoplasm of descending colon <input type="checkbox"/> C18.7 - Malignant neoplasm of sigmoid colon <input type="checkbox"/> C18.8 - Malignant neoplasm of overlapping sites of colon <input type="checkbox"/> C18.9 - Malignant neoplasm of colon, unspecified <input type="checkbox"/> C19 - Malignant neoplasm of rectosigmoid junction <input type="checkbox"/> C20 - Malignant neoplasm of rectum <input type="checkbox"/> C21.2 - Malignant neoplasm of cloacogenic zone <input type="checkbox"/> C21.8 - Malignant neoplasm of overlapping sites of rectum, anus and anal canal <input type="checkbox"/> C22.0 - Liver cell carcinoma <input type="checkbox"/> C22.1 - Intrahepatic bile duct carcinoma <input type="checkbox"/> C22.2 - Hepatoblastoma <input type="checkbox"/> C22.3 - Angiosarcoma of liver <input type="checkbox"/> C22.4 - Other sarcomas of liver <input type="checkbox"/> C22.7 - Other specified carcinomas of liver <input type="checkbox"/> C22.8 - Malignant neoplasm of liver, primary, unspecified as to type <input type="checkbox"/> C22.9 - Malignant neoplasm of liver, not specified as primary or secondary <input type="checkbox"/> C24.0 - Malignant neoplasm of extrahepatic bile duct <input type="checkbox"/> C24.9 - Malignant neoplasm of biliary tract, unspecified <input type="checkbox"/> C25.0 - Malignant neoplasm of head of pancreas <input type="checkbox"/> C25.1 - Malignant neoplasm of body of pancreas <input type="checkbox"/> C25.2 - Malignant neoplasm of tail of pancreas <input type="checkbox"/> C25.3 - Malignant neoplasm of pancreatic duct <input type="checkbox"/> C25.4 - Malignant neoplasm of endocrine pancreas <input type="checkbox"/> C25.7 - Malignant neoplasm of other parts of pancreas <input type="checkbox"/> C25.8 - Malignant neoplasm of overlapping sites of pancreas <input type="checkbox"/> C25.9 - Malignant neoplasm of pancreas, unspecified <input type="checkbox"/> C54.0 - Malignant neoplasm of isthmus uteri <input type="checkbox"/> C54.1 - Malignant neoplasm of endometrium <input type="checkbox"/> C54.2 - Malignant neoplasm of myometrium <input type="checkbox"/> C54.3 - Malignant neoplasm of fundus uteri <input type="checkbox"/> C54.8 - Malignant neoplasm of overlapping sites of corpus uteri <input type="checkbox"/> C54.9 - Malignant neoplasm of corpus uteri, unspecified <input type="checkbox"/> C55 - Malignant neoplasm of uterus, part unspecified <input type="checkbox"/> C56.1 - Malignant neoplasm of right ovary	<input type="checkbox"/> C56.2 - Malignant neoplasm of left ovary <input type="checkbox"/> C56.3 - Malignant neoplasm of bilateral ovaries <input type="checkbox"/> C56.9 - Malignant neoplasm of unspecified ovary <input type="checkbox"/> C57.00 - Malignant neoplasm of unspecified fallopian tube <input type="checkbox"/> C57.01 - Malignant neoplasm of right fallopian tube <input type="checkbox"/> C57.02 - Malignant neoplasm of left fallopian tube <input type="checkbox"/> C57.10 - Malignant neoplasm of unspecified broad ligament <input type="checkbox"/> C57.11 - Malignant neoplasm of right broad ligament <input type="checkbox"/> C57.12 - Malignant neoplasm of left broad ligament <input type="checkbox"/> C57.20 - Malignant neoplasm of unspecified round ligament <input type="checkbox"/> C57.21 - Malignant neoplasm of right round ligament <input type="checkbox"/> C57.22 - Malignant neoplasm of left round ligament <input type="checkbox"/> C57.3 - Malignant neoplasm of parametrium <input type="checkbox"/> C57.4 - Malignant neoplasm of uterine adnexa, unspecified <input type="checkbox"/> C64.1 - Malignant neoplasm of right kidney, except renal pelvis <input type="checkbox"/> C64.2 - Malignant neoplasm of left kidney, except renal pelvis <input type="checkbox"/> C64.9 - Malignant neoplasm of unspecified kidney, except renal pelvis <input type="checkbox"/> C65.1 - Malignant neoplasm of right renal pelvis <input type="checkbox"/> C65.2 - Malignant neoplasm of left renal pelvis <input type="checkbox"/> C65.9 - Malignant neoplasm of unspecified renal pelvis <input type="checkbox"/> C66.1 - Malignant neoplasm of right ureter <input type="checkbox"/> C66.2 - Malignant neoplasm of left ureter <input type="checkbox"/> C66.9 - Malignant neoplasm of unspecified ureter <input type="checkbox"/> C68.8 - Malignant neoplasm of overlapping sites of urinary organs <input type="checkbox"/> C71.0 - Malignant neoplasm of cerebrum, except lobes and ventricles <input type="checkbox"/> C71.1 - Malignant neoplasm of frontal lobe <input type="checkbox"/> C71.2 - Malignant neoplasm of temporal lobe <input type="checkbox"/> C71.3 - Malignant neoplasm of parietal lobe <input type="checkbox"/> C71.4 - Malignant neoplasm of occipital lobe <input type="checkbox"/> C71.5 - Malignant neoplasm of cerebral ventricle <input type="checkbox"/> C71.6 - Malignant neoplasm of cerebellum <input type="checkbox"/> C71.7 - Malignant neoplasm of brain stem <input type="checkbox"/> C71.8 - Malignant neoplasm of overlapping sites of brain <input type="checkbox"/> C71.9 - Malignant neoplasm of brain, unspecified <input type="checkbox"/> D12.0 - Benign neoplasm of cecum <input type="checkbox"/> D12.1 - Benign neoplasm of appendix <input type="checkbox"/> D12.2 - Benign neoplasm of ascending colon <input type="checkbox"/> D12.3 - Benign neoplasm of transverse colon <input type="checkbox"/> D12.4 - Benign neoplasm of descending colon <input type="checkbox"/> D12.5 - Benign neoplasm of sigmoid colon <input type="checkbox"/> D12.6 - Benign neoplasm of colon, unspecified <input type="checkbox"/> K63.5 - Polyp of colon <input type="checkbox"/> L85.3 - Xerosis cutis <input type="checkbox"/> Z85.00* - Personal history of malignant neoplasm of unspecified digestive organ <input type="checkbox"/> Z85.038* - Personal history of other malignant neoplasm of large intestine <input type="checkbox"/> Z85.048* - Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus <input type="checkbox"/> Z85.42* - Personal history of malignant neoplasm of other parts of uterus <input type="checkbox"/> Z85.43* - Personal history of malignant neoplasm of ovary <input type="checkbox"/> Z85.53* - Personal history of malignant neoplasm of renal pelvis <input type="checkbox"/> Z85.54* - Personal history of malignant neoplasm of ureter <input type="checkbox"/> Z85.59* - Personal history of malignant neoplasm of other urinary tract organ <input type="checkbox"/> Z85.841* - Personal history of malignant neoplasm of brain <input type="checkbox"/> Z86.010* - Personal history of colonic polyps
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Group 2

<input type="checkbox"/> C25.0 - Malignant neoplasm of head of pancreas <input type="checkbox"/> C25.1 - Malignant neoplasm of body of pancreas <input type="checkbox"/> C25.2 - Malignant neoplasm of tail of pancreas <input type="checkbox"/> C25.3 - Malignant neoplasm of pancreatic duct <input type="checkbox"/> C25.4 - Malignant neoplasm of endocrine pancreas <input type="checkbox"/> C25.7 - Malignant neoplasm of other parts of pancreas <input type="checkbox"/> C25.8 - Malignant neoplasm of overlapping sites of pancreas <input type="checkbox"/> C25.9 - Malignant neoplasm of pancreas, unspecified <input type="checkbox"/> C50.011 - Malignant neoplasm of nipple and areola, right female breast <input type="checkbox"/> C50.012 - Malignant neoplasm of nipple and areola, left female breast <input type="checkbox"/> C50.019 - Malignant neoplasm of nipple and areola, unspecified female breast <input type="checkbox"/> C50.021 - Malignant neoplasm of nipple and areola, right male breast <input type="checkbox"/> C50.022 - Malignant neoplasm of nipple and areola, left male breast <input type="checkbox"/> C50.029 - Malignant neoplasm of nipple and areola, unspecified male breast <input type="checkbox"/> C50.111 - Malignant neoplasm of central portion of right female breast <input type="checkbox"/> C50.112 - Malignant neoplasm of central portion of left female breast <input type="checkbox"/> C50.119 - Malignant neoplasm of central portion of unspecified female breast <input type="checkbox"/> C50.121 - Malignant neoplasm of central portion of right male breast <input type="checkbox"/> C50.122 - Malignant neoplasm of central portion of left male breast <input type="checkbox"/> C50.129 - Malignant neoplasm of central portion of unspecified male breast <input type="checkbox"/> C50.211 - Malignant neoplasm of upper-inner quadrant of right female breast <input type="checkbox"/> C50.212 - Malignant neoplasm of upper-inner quadrant of left female breast <input type="checkbox"/> C50.219 - Malignant neoplasm of upper-inner quadrant of unspecified female breast	<input type="checkbox"/> C50.521 - Malignant neoplasm of lower-outer quadrant of right male breast <input type="checkbox"/> C50.522 - Malignant neoplasm of lower-outer quadrant of left male breast <input type="checkbox"/> C50.529 - Malignant neoplasm of lower-outer quadrant of unspecified male breast <input type="checkbox"/> C50.611 - Malignant neoplasm of axillary tail of right female breast <input type="checkbox"/> C50.612 - Malignant neoplasm of axillary tail of left female breast <input type="checkbox"/> C50.619 - Malignant neoplasm of axillary tail of unspecified female breast <input type="checkbox"/> C50.621 - Malignant neoplasm of axillary tail of right male breast <input type="checkbox"/> C50.622 - Malignant neoplasm of axillary tail of left male breast <input type="checkbox"/> C50.629 - Malignant neoplasm of axillary tail of unspecified male breast <input type="checkbox"/> C50.811 - Malignant neoplasm of overlapping sites of right female breast <input type="checkbox"/> C50.812 - Malignant neoplasm of overlapping sites of left female breast <input type="checkbox"/> C50.819 - Malignant neoplasm of overlapping sites of unspecified female breast <input type="checkbox"/> C50.821 - Malignant neoplasm of overlapping sites of right male breast <input type="checkbox"/> C50.822 - Malignant neoplasm of overlapping sites of left male breast <input type="checkbox"/> C50.829 - Malignant neoplasm of overlapping sites of unspecified male breast <input type="checkbox"/> C50.911 - Malignant neoplasm of unspecified site of right female breast <input type="checkbox"/> C50.912 - Malignant neoplasm of unspecified site of left female breast <input type="checkbox"/> C50.919 - Malignant neoplasm of unspecified site of unspecified female breast <input type="checkbox"/> C50.921 - Malignant neoplasm of unspecified site of right male breast <input type="checkbox"/> C50.922 - Malignant neoplasm of unspecified site of left male breast <input type="checkbox"/> C50.929 - Malignant neoplasm of unspecified site of unspecified male breast <input type="checkbox"/> C56.1 - Malignant neoplasm of right ovary <input type="checkbox"/> C56.2 - Malignant neoplasm of left ovary
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Group 2 (Continued)	
<div><input type="checkbox"/> C50.221 - Malignant neoplasm of upper-inner quadrant of right male breast</div> <div><input type="checkbox"/> C50.222 - Malignant neoplasm of upper-inner quadrant of left male breast</div> <div><input type="checkbox"/> C50.229 - Malignant neoplasm of upper-inner quadrant of unspecified male breast</div> <div><input type="checkbox"/> C50.311 - Malignant neoplasm of lower-inner quadrant of right female breast</div> <div><input type="checkbox"/> C50.312 - Malignant neoplasm of lower-inner quadrant of left female breast</div> <div><input type="checkbox"/> C50.319 - Malignant neoplasm of lower-inner quadrant of unspecified female breast</div> <div><input type="checkbox"/> C50.321 - Malignant neoplasm of lower-inner quadrant of right male breast</div> <div><input type="checkbox"/> C50.322 - Malignant neoplasm of lower-inner quadrant of left male breast</div> <div><input type="checkbox"/> C50.329 - Malignant neoplasm of lower-inner quadrant of unspecified male breast</div> <div><input type="checkbox"/> C50.411 - Malignant neoplasm of upper-outer quadrant of right female breast</div> <div><input type="checkbox"/> C50.412 - Malignant neoplasm of upper-outer quadrant of left female breast</div> <div><input type="checkbox"/> C50.419 - Malignant neoplasm of upper-outer quadrant of unspecified female breast</div> <div><input type="checkbox"/> C50.421 - Malignant neoplasm of upper-outer quadrant of right male breast</div> <div><input type="checkbox"/> C50.422 - Malignant neoplasm of upper-outer quadrant of left male breast</div> <div><input type="checkbox"/> C50.429 - Malignant neoplasm of upper-outer quadrant of unspecified male breast</div> <div><input type="checkbox"/> C50.511 - Malignant neoplasm of lower-outer quadrant of right female breast</div> <div><input type="checkbox"/> C50.512 - Malignant neoplasm of lower-outer quadrant of left female breast</div> <div><input type="checkbox"/> C50.519 - Malignant neoplasm of lower-outer quadrant of unspecified female breast</div> <div><input type="checkbox"/> C56.3 - Malignant neoplasm of bilateral ovaries</div> <div><input type="checkbox"/> C56.9 - Malignant neoplasm of unspecified ovary</div>	<div><input type="checkbox"/> C57.00 - Malignant neoplasm of unspecified fallopian tube</div> <div><input type="checkbox"/> C57.01 - Malignant neoplasm of right fallopian tube</div> <div><input type="checkbox"/> C57.02 - Malignant neoplasm of left fallopian tube</div> <div><input type="checkbox"/> C61 - Malignant neoplasm of prostate</div> <div><input type="checkbox"/> D05.00 - Lobular carcinoma in situ of unspecified breast</div> <div><input type="checkbox"/> D05.01 - Lobular carcinoma in situ of right breast</div> <div><input type="checkbox"/> D05.02 - Lobular carcinoma in situ of left breast</div> <div><input type="checkbox"/> D05.10 - Intraductal carcinoma in situ of unspecified breast</div> <div><input type="checkbox"/> D05.11 - Intraductal carcinoma in situ of right breast</div> <div><input type="checkbox"/> D05.12 - Intraductal carcinoma in situ of left breast</div> <div><input type="checkbox"/> D05.80 - Other specified type of carcinoma in situ of unspecified breast</div> <div><input type="checkbox"/> D05.81 - Other specified type of carcinoma in situ of right breast</div> <div><input type="checkbox"/> D05.82 - Other specified type of carcinoma in situ of left breast</div> <div><input type="checkbox"/> D05.90 - Unspecified type of carcinoma in situ of unspecified breast</div> <div><input type="checkbox"/> D05.91 - Unspecified type of carcinoma in situ of right breast</div> <div><input type="checkbox"/> D05.92 - Unspecified type of carcinoma in situ of left breast</div> <div><input type="checkbox"/> Z85.07 - Personal history of malignant neoplasm of pancreas</div> <div><input type="checkbox"/> Z85.3 - Personal history of malignant neoplasm of breast</div> <div><input type="checkbox"/> Z85.43 - Personal history of malignant neoplasm of ovary</div> <div><input type="checkbox"/> Z85.46 - Personal history of malignant neoplasm of prostate</div>
Group 3	Group 4
<div><input type="checkbox"/> C16.0 - Malignant neoplasm of cardia</div> <div><input type="checkbox"/> C16.1 - Malignant neoplasm of fundus of stomach</div> <div><input type="checkbox"/> C16.2 - Malignant neoplasm of body of stomach</div> <div><input type="checkbox"/> C16.3 - Malignant neoplasm of pyloric antrum</div> <div><input type="checkbox"/> C16.4 - Malignant neoplasm of pylorus</div> <div><input type="checkbox"/> C16.5 - Malignant neoplasm of lesser curvature of stomach, unspecified</div> <div><input type="checkbox"/> C16.6 - Malignant neoplasm of greater curvature of stomach, unspecified</div> <div><input type="checkbox"/> C16.8 - Malignant neoplasm of overlapping sites of stomach</div> <div><input type="checkbox"/> C16.9 - Malignant neoplasm of stomach, unspecified</div> <div><input type="checkbox"/> C17.0 - Malignant neoplasm of duodenum</div> <div><input type="checkbox"/> C17.1 - Malignant neoplasm of jejunum</div> <div><input type="checkbox"/> C17.2 - Malignant neoplasm of ileum</div> <div><input type="checkbox"/> C17.3 - Meckel's diverticulum, malignant</div> <div><input type="checkbox"/> C17.8 - Malignant neoplasm of overlapping sites of small intestine</div> <div><input type="checkbox"/> C17.9 - Malignant neoplasm of small intestine, unspecified</div> <div><input type="checkbox"/> C18.0 - Malignant neoplasm of cecum</div> <div><input type="checkbox"/> C18.1 - Malignant neoplasm of appendix</div> <div><input type="checkbox"/> C18.2 - Malignant neoplasm of ascending colon</div> <div><input type="checkbox"/> C18.3 - Malignant neoplasm of hepatic flexure</div> <div><input type="checkbox"/> C18.4 - Malignant neoplasm of transverse colon</div>	<div><input type="checkbox"/> C43.1 - Malignant melanoma of eyelid, including canthus</div> <div><input type="checkbox"/> C43.2 - Malignant melanoma of ear and external auricular canal</div> <div><input type="checkbox"/> C43.3 - Malignant melanoma of other and unspecified parts of face</div> <div><input type="checkbox"/> C43.4 - Malignant melanoma of scalp and neck</div> <div><input type="checkbox"/> C43.5 - Malignant melanoma of trunk</div> <div><input type="checkbox"/> C43.0 - Malignant melanoma of lip</div> <div><input type="checkbox"/> C43 - Malignant melanoma of skin</div> <div><input type="checkbox"/> C43.6 - Malignant melanoma of upper limb, including shoulder</div> <div><input type="checkbox"/> C43.7 - Malignant melanoma of lower limb, including hip</div> <div><input type="checkbox"/> C43.8 - Overlapping malignant melanoma of skin</div> <div><input type="checkbox"/> C43.9 - Malignant melanoma of skin, unspecified</div> <div><input type="checkbox"/> C44 - Other malignant neoplasms of skin</div> <div><input type="checkbox"/> C44.0 - Skin of lip</div> <div><input type="checkbox"/> C44.1 - Skin of eyelid, including canthus</div> <div><input type="checkbox"/> C44.2 - Skin of ear and external auricular canal</div> <div><input type="checkbox"/> C44.3 - Skin of other and unspecified parts of face</div> <div><input type="checkbox"/> C44.4 - Skin of scalp and neck</div> <div><input type="checkbox"/> C44.5 - Skin of trunk</div> <div><input type="checkbox"/> C44.6 - Skin of upper limb, including shoulder</div> <div><input type="checkbox"/> C44.7 - Skin of lower limb, including hip</div> <div><input type="checkbox"/> G47.35 - Congenital central alveolar hypoventilation syndrome</div> <div><input type="checkbox"/> E66.2 - Morbid (severe) obesity with alveolar hypoventilation</div> <div><input type="checkbox"/> Z85.36 - Sleep related hypoventilation in conditions classd elswhr</div> <div><input type="checkbox"/> G47.34 - Idio sleep related nonobstructive alveolar hypoventilation</div>
Group 5	Group 8
<div><input type="checkbox"/> Diabetes due to underlying conditions (codes that start with E08)</div> <div><input type="checkbox"/> Drug or chemical induced diabetes (codes that start with E09)</div> <div><input type="checkbox"/> Type 1 diabetes (codes that start with E10)</div> <div><input type="checkbox"/> Type 2 diabetes (codes that start with E11)</div> <div><input type="checkbox"/> Diabetes related to pregnancy (codes that start with 024)</div> <div><input type="checkbox"/> Other types of diabetes not covered by the previous categories (codes that start with E13)</div> <div><input type="checkbox"/> E31.21 - Multiple endocrine neoplasia [MEN] type I</div> <div><input type="checkbox"/> E31.22 - Multiple endocrine neoplasia [MEN] type IIA</div> <div><input type="checkbox"/> E31.23 - Multiple endocrine neoplasia [MEN] type IIB</div> <div><input type="checkbox"/> E31.20 - Multiple endocrine neoplasia [MEN] syndrome, unspecified</div> <div><input type="checkbox"/> Z83.41 - Family history of multiple endocrine neoplasia syndrome</div> <div><input type="checkbox"/> E31.0 - Autoimmune polyglandular failure</div> <div><input type="checkbox"/> E31.8 - Other polyglandular dysfunction</div> <div><input type="checkbox"/> E31.9 - Polyglandular dysfunction, unspecified</div>	
Group 6 (Any code from Group A is also qualified)	Group 8
<div><input type="checkbox"/> Q85.00 - Neurofibromatosis, unspecified</div> <div><input type="checkbox"/> Q85.01 - Neurofibromatosis, type 1</div> <div><input type="checkbox"/> Q85.02 - Neurofibromatosis, type 2</div> <div><input type="checkbox"/> Q85.09 - Other neurofibromatosis</div> <div><input type="checkbox"/> E21.0 - Primary hyperparathyroidism</div> <div><input type="checkbox"/> Q85.03 - Schwannomatosis</div> <div><input type="checkbox"/> Q85.0 Neurofibromatosis (nonmalignant)</div> <div><input type="checkbox"/> Q85.03 - Schwannomatosis</div>	
Group 7	<div><input type="checkbox"/> G11.3 - Cerebellar ataxia with defective DNA repair</div> <div><input type="checkbox"/> G11.10 - Early-onset cerebellar ataxia, unspecified</div> <div><input type="checkbox"/> G11.11 - Friedreich ataxia</div> <div><input type="checkbox"/> G11.19 - Other early-onset cerebellar ataxia</div> <div><input type="checkbox"/> G11.0 - Congenital nonprogressive ataxia</div> <div><input type="checkbox"/> G11.2 - Late-onset cerebellar ataxia</div> <div><input type="checkbox"/> G11.4 - Hereditary spastic paraplegia</div> <div><input type="checkbox"/> G11.8 - Other hereditary ataxias</div> <div><input type="checkbox"/> G11.9 - Hereditary ataxia, unspecified</div> <div><input type="checkbox"/> Q85.00 - Neurofibromatosis, unspecified</div> <div><input type="checkbox"/> Q85.01 - Neurofibromatosis, type 1</div> <div><input type="checkbox"/> Q85.02 - Neurofibromatosis, type 2</div> <div><input type="checkbox"/> Q85.09 - Other neurofibromatosis</div> <div><input type="checkbox"/> E21.0 - Primary hyperparathyroidism</div> <div><input type="checkbox"/> Q85.03 - Schwannomatosis</div> <div><input type="checkbox"/> Q85.0 Neurofibromatosis (nonmalignant)</div> <div><input type="checkbox"/> Q85.03 - Schwannomatosis</div> <div><input type="checkbox"/> Q85.1 - Tuberous sclerosis</div> <div><input type="checkbox"/> Q85.8 - Other phakomatoses, not elsewhere classified</div> <div><input type="checkbox"/> Q85.9 - Phakomatosis, unspecified</div>
<div><input type="checkbox"/> Q85.1 - Tuberous sclerosis</div> <div><input type="checkbox"/> Q85.8 - Other phakomatoses, not elsewhere classified</div> <div><input type="checkbox"/> Q85.9 - Phakomatosis, unspecified</div> <div><input type="checkbox"/> Q85 - Phakomatoses, not elsewhere classified</div> <div><input type="checkbox"/> Q85.00 - Neurofibromatosis, unspecified</div> <div><input type="checkbox"/> Q85.01 - Neurofibromatosis, type 1</div> <div><input type="checkbox"/> Q85.02 - Neurofibromatosis, type 2</div> <div><input type="checkbox"/> Q85.09 - Other neurofibromatosis</div> <div><input type="checkbox"/> E21.0 - Primary hyperparathyroidism</div> <div><input type="checkbox"/> Q85.03 - Schwannomatosis</div> <div><input type="checkbox"/> Q85.0 Neurofibromatosis (nonmalignant)</div>	

Patient Informed Consent for Genetic Testing

I, _____ The Patient authorize PreCheck Health Services, Inc., to conduct genetic testing for **CANCER 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 authorized 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 benefits 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: _____,
Notifier: PreCheck Health Services

Patient ID Number: _____

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: ____/____/____.