IMMUNOLOGY GENETIC 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: _____

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.

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

QUESTIONNAIRE

1. Is there any previous genetic testing for autoimmune diseases?
   ☐ Yes ☐ No
2. Any inherited autoimmune disorders run in families?
   ☐ Yes ☐ No
3. Any recurrent associations of Autoimmune Diseases in family members from the below list?
   ☐ Yes ☐ No
   - 3.1. Autoimmune thyroid disease (AITD)
   - 3.2. Systemic sclerosis (SSc)
   - 3.3. Rheumatoid arthritis (RA)
   - 3.4. Systemic lupus erythematosus (SLE).
   - 3.5. Others
4. Signs and symptoms of primary immunodeficiency
   - ☐ 4.1. Frequent and recurrent pneumonia
   - ☐ 4.2. Bronchitis
   - ☐ 4.3. Sinus infections
   - ☐ 4.4. Ear infections
   - ☐ 4.5. Meningitis or Skin infections
   - ☐ 4.6. Inflammation and infection of internal organs
   - ☐ 4.7. Blood disorders, such as low platelet count or anemia
5. Is someone else in the family living with neutropenia?
   ☐ Yes ☐ No
6. Family or personal history of B-cell lymphoproliferative disorders?
   ☐ Yes ☐ No
7. Family or personal history of Human immunodeficiency virus / acquired immune deficiency syndrome (HIV/AIDS)?
   ☐ Yes ☐ No
8. Any unusual frequent or severe infections occurs in family members?
   ☐ Yes ☐ No
9. Family or personal history of leukemia. immune-complex diseases, like viral hepatitis?
   ☐ Yes ☐ No

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

COMPREHENSIVE TARGETED IMMUNOLOGY GENETIC TEST

	Number of Genes: 291		

Gene List

ADA, ADA2, ADAM17, AICDA, AIRE, AK2, AP1S3, AP3B1, AP3D1, ARX, ATM, ATRX, B2M, BCL10, BLM, BLNK, BTK, C1QA, C1QB, C1QC, C1R, C1S, C2, C3, C5, C6, C7, C8A, C8B, C9, CARD9, CARD11, CARD14, CASP8, CASP10, CCNO, CD19, CD27, CD40, CD40LG, CD46, CD55, CD59, CD79A, CD79B, CD247, CDKL5, CEBPA, CEBPE, CFD, CFH, CFI, CFP, CFTR, CIITA, CLCN7, COL7A1, CORO1A, CR2, CSF2RA, CSF2RB, CSF3R, CTLA4, CTPS1, CTSC, CXCR4, CYBA, CYBB, DCLRE1C, DEF6, DGKE, DNASE1L3, DNASE2, DOCK8, DTNBP1, ELANE, EPG5, ETV6, EXTL3, F9, FANCC, FAS, FASLG, FERMT3, FGD1, FMR1, FOXN1, FOXP3, G6PC1, G6PC3, G6PD, GATA2, GFI1, HAX1, HMOX1, HPS1, HPS3, HPS4, HPS5, HPS6, HUWE1, ICOS, IFIH1, IFNAR1, IFNAR2, IFNGR1, IFNGR2, IGHM, IGLL1, IKBKB, IKZF1, IL1RAPL1, IL1RN, IL2RA, IL2RG, IL6R, IL6ST, IL7R, IL10RA, IL10RB, IL12B, IL12RB1, IL17RA, IL21R, IL36RN, IRAK4, IRF4, IRF8, ISG15, ITCH, ITGB2, ITK, JAGN1, JAK1, JAK3, KDM5C, KRAS, L1CAM, LCK, LIG1, LIG4, LPIN2, LRBA, LYST, MAGT1, MALT1, MAP3K14, MASP2, MC2R, MCM4, MECP2, MED12, MEFV, MID1, MPL, MRTFA, MSH6, MTHFD1, MVK, MYD88, MYH9, NBN, NCF1, NCF2, NCF4, NCSTN, NFE2L2, NFKB1, NFKB2, NFKBIA, NHEJ1, NHP2, NLRC4, NLRP1, NLRP3, NLRP12, NOD2, OAS1, OCRL, ORAI1, PALB2, PARN, PAX1, PEPD, PGM3, PI4KA, PIK3CD, PIK3CG, PIK3R1, PLCG2, PMS2, PNP, POLA1, POMP, PRF1, PRG4, PRKCD, PRKDC, PSENEN, PSMB8, PSTPIP1, PTEN, PTPRC, RAB27A, RAC2, RAG1, RAG2, RASGRP1, RBCK1, REL, RFX5, RFXANK, RFXAP, RHOH, RIGI, RMRP, RNASEH2A, RNASEH2B, RNASEH2C, RNF168, RORC, RPS6KA3, RTEL1, RUNX1, SAMD9, SAMHD1, SBDS, SERPING1, SH2D1A, SKIC2, SKIC3, SLC7A7, SLC16A2, SLC29A3, SLC35A1, SLC35C1, SLC37A4, SLC39A4, SLC46A1, SMARCAL1, SOCS1, SP110, SPINK5, SRP72, STAT1, STAT2, STAT3, STAT5B, STIM1, STING1, STK4, STX11, STXBP2, TAFAZZIN, TAP1, TAP2, TAPBP, TBK1, TBX1, TCF3, TERC, TERT, TICAM1, TINF2, TLR7, TMC6, TMC8, TNFAIP3, TNFRSF1A, TNFRSF9, TNFRSF13B, TP53, TPP2, TRAF3, TRAF3IP2, TREX1, TRNT1, TTC7A, TYK2, UNC13D, UNC93B1, UNG, USB1, VPS13B, VPS45, WAS, WIPF1, WRAP53, XIAP, ZAP70, ZBTB24.

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.

ICD-10 DX Code (s):

Group 1

- ☐ D80.0 Hereditary hypogammaglobulinaemia
- ☐ D80.1 Nonfamilial hypogammaglobulinaemia
- ☐ D80.2 Selective deÿciency of immunoglobulin A [IgA]
- ☐ D80.3 Selective deÿciency of immunoglobulin G [IgG] subclasses
- ☐ D80.4 Selective deÿciency of immunoglobulin M [IgM]
- ☐ D80.5 Immunodeÿciency with increased immunoglobulin M [IgM]
- ☐ D80.6 Antibody deÿciency with near-normal immunoglobulins or with hyperimmunoglobulinaemia
- ☐ D80.7 Transient hypogammaglobulinaemia of infancy
- ☐ D80.8 Other immunodeÿciencies with predominantly antibody defects
- ☐ D80.9 Immunodeÿciency with predominantly antibody defects, unspeciÿed
- ☐ D81.0 Severe combined immunodeÿciency [SCID] with reticular dysgenesis
- ☐ D81.1 Severe combined immunodeÿciency [SCID] with low T- and B-cell numbers
- ☐ D81.2 Severe combined immunodeÿciency [SCID] with low or normal B-cell numbers
- ☐ D81.3 Adenosine deaminase [ADA] deÿciency
- ☐ D81.4 Nezelof syndrome
- ☐ D81.5 Purine nucleoside phosphorylase [PNP] deÿciency
- ☐ D81.6 Major histocompatibility complex class I deÿciency
- ☐ D81.7 Major histocompatibility complex class II deÿciency
- ☐ D81.8 Other combined immunodeÿciencies
- ☐ D81.9 Combined immunodeÿciency, unspeciÿed
- ☐ D82.0 Wiskott-Aldrich syndrome
- ☐ D82.1 Di George syndrome
- ☐ D82.2 Immunodeÿciency with short-limbed stature
- ☐ D82.3 Immunodeÿciency following hereditary defective response to Epstein-Barr virus
- ☐ D82.4 Hyperimmunoglobulin E [IgE] syndrome
- ☐ D82.8 Immunodeÿciency associated with other speciÿed major defects
- ☐ D82.9 Immunodeÿciency associated with major defect, unspeciÿed
- ☐ D83.0 Common variable immunodeÿciency with predominant abnormalities of B-cell numbers and function
- ☐ D83.1 Common variable immunodeÿciency with predominant immunoregulatory T-cell disorders
- ☐ D83.2 Common variable immunodeÿciency with autoantibodies to B- or T-cells
- ☐ D83.8 Other common variable immunodeÿciencies
- ☐ D83.9 Common variable immunodeÿciency, unspeciÿed
- ☐ D84.0 Lymphocyte function antigen-1 [LFA-1] defect
- ☐ D84.1 Defects in the complement system
- ☐ D84.8 Other speciÿed immunodeÿciencies
- ☐ D84.9 Immunodeÿciency, unspeciÿed
- ☐ D86.0 Sarcoidosis of lung
- ☐ D86.1 Sarcoidosis of lymph nodes
- ☐ D86.2 Sarcoidosis of lung with sarcoidosis of lymph nodes
- ☐ D86.3 Sarcoidosis of skin
- ☐ D86.8 Sarcoidosis of other and combined sites
- ☐ D86.9 Sarcoidosis, unspeciÿed
- ☐ D89.0 Polyclonal hypergammaglobulinaemia
- ☐ D89.1 Cryoglobulinaemia
- ☐ D89.2 Hypergammaglobulinaemia, unspeciÿed
- ☐ D89.3 Immune reconstitution syndrome
- ☐ D89.8 Other speciÿed disorders involving the immune mechanism, not elsewhere classiÿed
- ☐ D89.9 Disorder involving the immune mechanism, unspeciÿed
- ☐ M05 Seropositive rheumatoid arthritis
- ☐ M05.0 Felty syndrome
- ☐ M05.1 Rheumatoid lung disease
- ☐ M05.2 Rheumatoid vasculitis
- ☐ M05.3
- ☐ M05.8 Other seropositive rheumatoid arthritis
- ☐ M05.9 Seropositive rheumatoid arthritis, unspeciÿed
- ☐ M06.0 Seronegative rheumatoid arthritis
- ☐ M06.1 Adult-onset Still disease
- ☐ M06.2 Rheumatoid bursitis
- ☐ M06.3 Rheumatoid nodule
- ☐ M06.4 In°amma tory polyarthropathy
- ☐ M06.8 Other speciÿed rheumatoid arthritis
- ☐ M06.9 Rheumatoid arthritis, unspeciÿed
- ☐ M32.0 Drug-induced systemic lupus erythematosus
- ☐ M32.1 Systemic lupus erythematosus with organ or system involvement
- ☐ M32.8 Other forms of systemic lupus erythematosus
- ☐ M32.9 Systemic lupus erythematosus, unspeciÿed
- ☐ M34.0 Progressive systemic sclerosis
- ☐ M34.1 CR(E)ST syndrome
- ☐ M34.2 Systemic sclerosis induced by drugs and chemicals
- ☐ M34.8 Other forms of systemic sclerosis
- ☐ M34.9 Systemic sclerosis, unspeciÿed

Group 2

- ☐ C16.0 Malignant neoplasm of cardia
- ☐ C16.1 Malignant neoplasm of fundus of stomach
- ☐ C16.2 Malignant neoplasm of body of stomach
- ☐ C16.3 Malignant neoplasm of pyloric antrum
- ☐ C16.4 Malignant neoplasm of pylorus
- ☐ C16.5 Malignant neoplasm of lesser curvature of stomach, unspeciÿed
- ☐ C16.6 Malignant neoplasm of greater curvature of stomach, unspeciÿed
- ☐ C16.8 Malignant neoplasm of overlapping sites of stomach
- ☐ C16.9 Malignant neoplasm of stomach, unspeciÿed
- ☐ C17.0 Malignant neoplasm of duodenum
- ☐ C17.1 Malignant neoplasm of jejunum
- ☐ C17.2 Malignant neoplasm of ileum
- ☐ C17.3 Meckel's diverticulum, malignant
- ☐ C17.8 Malignant neoplasm of overlapping sites of small intestine
- ☐ C17.9 Malignant neoplasm of small intestine, unspeciÿed
- ☐ C18.0 Malignant neoplasm of cecum
- ☐ C18.1 Malignant neoplasm of appendix
- ☐ C18.2 Malignant neoplasm of ascending colon
- ☐ C18.3 Malignant neoplasm of hepatic °e xure
- ☐ C18.4 Malignant neoplasm of transverse colon
- ☐ C18.5 Malignant neoplasm of splenic °e xure
- ☐ C18.6 Malignant neoplasm of descending colon
- ☐ C18.7 Malignant neoplasm of sigmoid colon
- ☐ C18.8 Malignant neoplasm of overlapping sites of colon
- ☐ C18.9 Malignant neoplasm of colon, unspeciÿed
- ☐ C19 Malignant neoplasm of rectosigmoid junction
- ☐ C20 Malignant neoplasm of rectum
- ☐ C21.2 Malignant neoplasm of cloacogenic zone
- ☐ C21.8 Malignant neoplasm of overlapping sites of rectum, anus and anal canal
- ☐ C22.0 Liver cell carcinoma
- ☐ C22.1 Intrahepatic bile duct carcinoma
- ☐ C22.2 Hepatoblastoma
- ☐ C56.2 Malignant neoplasm of left ovary
- ☐ C56.3 Malignant neoplasm of bilateral ovaries
- ☐ C56.9 Malignant neoplasm of unspeciÿed ovary
- ☐ C57.00 Malignant neoplasm of unspeciÿed fallopian tube
- ☐ C57.01 Malignant neoplasm of right fallopian tube
- ☐ C57.02 Malignant neoplasm of left fallopian tube
- ☐ C57.10 Malignant neoplasm of unspeciÿed broad ligament
- ☐ C57.11 Malignant neoplasm of right broad ligament
- ☐ C57.12 Malignant neoplasm of left broad ligament
- ☐ C57.20 Malignant neoplasm of unspeciÿed round ligament
- ☐ C57.21 Malignant neoplasm of right round ligament
- ☐ C57.22 Malignant neoplasm of left round ligament
- ☐ C57.3 Malignant neoplasm of parametrium
- ☐ C57.4 Malignant neoplasm of uterine adnexa, unspeciÿed
- ☐ C64.1 Malignant neoplasm of right kidney, except renal pelvis
- ☐ C64.2 Malignant neoplasm of left kidney, except renal pelvis
- ☐ C64.9 Malignant neoplasm of unspeciÿed kidney, except renal pelvis
- ☐ C65.1 Malignant neoplasm of right renal pelvis
- ☐ C65.2 Malignant neoplasm of left renal pelvis
- ☐ C65.9 Malignant neoplasm of unspeciÿed renal pelvis
- ☐ C66.1 Malignant neoplasm of right ureter
- ☐ C66.2 Malignant neoplasm of left ureter
- ☐ C66.9 Malignant neoplasm of unspeciÿed ureter
- ☐ C68.8 Malignant neoplasm of overlapping sites of urinary organs
- ☐ C71.0 Malignant neoplasm of cerebrum, except lobes and ventricles
- ☐ C71.1 Malignant neoplasm of frontal lobe
- ☐ C71.2 Malignant neoplasm of temporal lobe
- ☐ C71.3 Malignant neoplasm of parietal lobe
- ☐ C71.4 Malignant neoplasm of occipital lobe
- ☐ C71.5 Malignant neoplasm of cerebral ventricle
- ☐ C71.6 Malignant neoplasm of cerebellum
- ☐ C71.7 Malignant neoplasm of brain stem

Group 2 (Continued)

- ☐ C22.3 Angiosarcoma of liver
- ☐ C22.4 Other sarcomas of liver
- ☐ C22.7 Other speciÿed carcinomas of liver
- ☐ C22.8 Malignant neoplasm of liver, primary, unspeciÿed as to type
- ☐ C22.9 Malignant neoplasm of liver, not speciÿed as primary or secondary
- ☐ C24.0 Malignant neoplasm of extrahepatic bile duct
- ☐ C24.9 Malignant neoplasm of biliary tract, unspeciÿed
- ☐ C25.0 Malignant neoplasm of head of pancreas
- ☐ C25.1 Malignant neoplasm of body of pancreas
- ☐ C25.2 Malignant neoplasm of tail of pancreas
- ☐ C25.3 Malignant neoplasm of pancreatic duct
- ☐ C25.4 Malignant neoplasm of endocrine pancreas
- ☐ C25.7 Malignant neoplasm of other parts of pancreas
- ☐ C25.8 Malignant neoplasm of overlapping sites of pancreas
- ☐ C25.9 Malignant neoplasm of pancreas, unspeciÿed
- ☐ C54.0 Malignant neoplasm of isthmus uteri
- ☐ C54.1 Malignant neoplasm of endometrium
- ☐ C54.2 Malignant neoplasm of myometrium
- ☐ C54.3 Malignant neoplasm of fundus uteri
- ☐ C54.8 Malignant neoplasm of overlapping sites of corpus uteri
- ☐ C54.9 Malignant neoplasm of corpus uteri, unspeciÿed
- ☐ C55 Malignant neoplasm of uterus, part unspeciÿed
- ☐ C56.1 Malignant neoplasm of right ovary

Group 3

- ☐ D80.5 Immunodeÿciency with increased immunoglobulin M [IgM]
- ☐ D82.4 Hyperimmunoglobulin E [IgE] syndrome
- ☐ D80.4 Selective deÿciency of immunoglobulin M [IgM]
- ☐ D68.0 Von Willebrand's disease
- ☐ D68.0 ngiohemophilia
- ☐ D68.0 Factor VIII deÿciency with vascular defect
- ☐ D68.0 Vascular hemophilia
- ☐ D69.1 Qualitative platelet defects
- ☐ D69.2 Other nonthrombocytopenic purpura
- ☐ D69.3 Idiopathic thrombocytopenic purpura
- ☐ D69.4 Other primary thrombocytopenia
- ☐ D69.5 Secondary thrombocytopenia
- ☐ D69.6 Thrombocytopenia, unspeciÿed
- ☐ D69.8 Other speciÿed haemorrhagic conditions
- ☐ D69.9 Haemorrhagic condition, unspeciÿed

Group 5

- ☐ E31 Polyglandular dysfunction
- ☐ E31.0 Autoimmune polyglandular failure
- ☐ E31.1 Polyglandular hyperfunction
- ☐ E31.2 Multiple endocrine neoplasia [MEN] syndromes
- ☐ E31.20 Multiple endocrine neoplasia [MEN] syndrome, unspeciÿed
- ☐ E31.21 Multiple endocrine neoplasia [MEN] type I
- ☐ E31.22 Multiple endocrine neoplasia [MEN] type IIA
- ☐ E31.23 Multiple endocrine neoplasia [MEN] type IIB
- ☐ E31.8 Other polyglandular dysfunction
- ☐ E31.9 Polyglandular dysfunction, unspeciÿed
- ☐ D80.0 Hereditary hypogammaglobulinaemia
- ☐ D80.1 Nonfamilial hypogammaglobulinaemia
- ☐ D80.2 Selective deÿciency of immunoglobulin A [IgA]
- ☐ D80.3 Selective deÿciency of immunoglobulin G [IgG] subclasses
- ☐ D80.4 Selective deÿciency of immunoglobulin M [IgM]
- ☐ D80.5 Immunodeÿciency with increased immunoglobulin M [IgM]
- ☐ D80.6 Antibody deÿciency with near-normal immunoglobulins or with hyperimmunoglobulinaemia
- ☐ D80.7 Transient hypogammaglobulinaemia of infancy
- ☐ D80.8 Other immunodeÿciencies with predominantly antibody defects
- ☐ D80.9 Immunodeÿciency with predominantly antibody defects, unspeciÿed

Group 6

- ☐ D89.8 Other speciÿed disorders involving the immune mechanism, not elsewhere classiÿed
- ☐ D89.9 Disorder involving the immune mechanism, unspeciÿed

- ☐ C71.8 Malignant neoplasm of overlapping sites of brain
- ☐ C71.9 Malignant neoplasm of brain, unspeciÿed
- ☐ D12.0 Benign neoplasm of cecum
- ☐ D12.1 Benign neoplasm of appendix
- ☐ D12.2 Benign neoplasm of ascending colon
- ☐ D12.3 Benign neoplasm of transverse colon
- ☐ D12.4 Benign neoplasm of descending colon
- ☐ D12.5 Benign neoplasm of sigmoid colon
- ☐ D12.6 Benign neoplasm of colon, unspeciÿed
- ☐ K63.5 Polyp of colon
- ☐ L85.3 Xerosis cutis
- ☐ Z85.00* Personal history of malignant neoplasm of unspeciÿed digestive organ
- ☐ Z85.038* Personal history of other malignant neoplasm of large intestine
- ☐ Z85.048* Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
- ☐ Z85.42* Personal history of malignant neoplasm of other parts of uterus
- ☐ Z85.43* Personal history of malignant neoplasm of ovary
- ☐ Z85.53* Personal history of malignant neoplasm of renal pelvis
- ☐ Z85.54* Personal history of malignant neoplasm of ureter
- ☐ Z85.59* Personal history of malignant neoplasm of other urinary tract organ
- ☐ Z85.841* Personal history of malignant neoplasm of brain
- ☐ Z86.010* Personal history of colonic polyps

Group 4

- ☐ D81.0 Severe combined immunodeÿciency with reticular dysgenesis
- ☐ D81.1 Severe combined immunodeÿciency [SCID] with low T- and B-cell numbers
- ☐ D81.2 Severe combined immunodeÿciency [SCID] with low or normal B-cell numbers
- ☐ D81.3 Adenosine deaminase [ADA] deÿciency
- ☐ D81.4 Nezelof syndrome
- ☐ D81.5 Purine nucleoside phosphorylase [PNP] deÿciency
- ☐ D81.6 Major histocompatibility complex class I deÿciency
- ☐ D81.7 Major histocompatibility complex class II deÿciency
- ☐ D81.8 Other combined immunodeÿciencies
- ☐ D81.9 Combined immunodeÿciency, unspeciÿed
- ☐ Q87.0 Congenital malformation syndromes predominantly a˝ ecting facial appearance
- ☐ Q87.1 Congenital malformation syndromes predominantly associated with short stature
- ☐ Q87.2 Congenital malformation syndromes predominantly involving limbs
- ☐ Q87.3 Congenital malformation syndromes involving early overgrowth
- ☐ Q87.4 Marfan syndrome
- ☐ Q87.5 Other congenital malformation syndromes with other skeletal changes
- ☐ Q87.8 Other speciÿed congenital malformation syndromes, not elsewhere classiÿed

Group 7

- ☐ G11.3 Cerebellar ataxia with defective DNA repair
- ☐ G11.10 Early-onset cerebellar ataxia, unspeciÿed
- ☐ G11.11 Friedreich ataxia
- ☐ G11.19 Other early-onset cerebellar ataxia
- ☐ G11.0 Congenital nonprogressive ataxia
- ☐ G11.2 Late-onset cerebellar ataxia
- ☐ G11.4 Hereditary spastic paraplegia
- ☐ G11.8 Other hereditary ataxias
- ☐ G11.9 Hereditary ataxia, unspeciÿed
- ☐ Q85.00 Neuroÿbromatosis, unspeciÿed
- ☐ Q85.01 Neuroÿbromatosis, type 1
- ☐ Q85.02 Neuroÿbromatosis, type 2
- ☐ Q85.09 Other¸neuroÿbromatosis
- ☐ E21.0 Primary hyperparathyroidism
- ☐ Q85.03 chwannomatosis
- ☐ Q85.0¸ oÿbromatosis¸(nonmalignant)
- ☐ Q85.03 chwannomatosis
- ☐ Q85.1 uberous¸sclerosis
- ☐ Q85.8 Other phakomatoses, not elsewhere classiÿed
- ☐ Q85.9 Phakomatosis, unspeciÿed

Patient Informed Consent for Genetic Testing

I, _____The Patient authorize PreCheck Health Services, Inc., to conduct genetic testing for IMMUNO 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: _____/_____/_____.