RxMatch® ORDER FORM

Phone: (435) 251-5740 • Fax: (385) 297-2385
genomics@imail.org

Intermountain® Precision Genomics

PATIENT INFORMATION *(required)*

Last Name		First Name	
Patient ID/MRN		Date of Birth _______ / _______ / _______	Sex Assigned at Birth Male Female
Street Address		City	State Zip Code
Phone Number ( ) -	Race African-American Asian Caucasian Hispanic Ashekenazi Jewish Other		

CLINIC INFORMATION

Ordering Physician	NPI	Clinic Name	Clinic Phone ( ) -
Fax ( ) -	Email	Clinic Address	

COLLECTION INFORMATION

Date & Time Collected ________ /________ /_______ _______: _______	Collected By (print)	Initial

BILLING INFORMATION *(Enclose a copy of the front and back of patient's insurance card(s) and patient demographic)*

Billing Method:

Insurance Medicare Medicaid Hospital/Institution Self-Pay* (signature) ___________________________________

Primary Insurance		Policy #	Group #
Insured Name	Relation to Insured	Insured Date of Birth	
Claims Address			

ICD 10 DIAGNOSIS CODE(S): [REQUIRED]

(Insurance companies require patient-specific ICD-10 codes to determine medical necessity of pharmacogenetics testing)

Primary ICD 10 Code	Additional ICD 10 Code(s) (may have up to three)	Patient has had a blood transfusion No Yes ______ / ______ / _____	Patient has been recipient of non-autologous BMT No Yes** ***IPG is unable to perform testing on these individuals*

COMMENTS OR SPECIAL INSTRUCTIONS

	Provider Signature	Date

**By signing, you acknowledge that you are aware of and agree to the following terms in declining to have your insurance billed:*

- *You are responsible to submit payment in full. (Please note payment arrangements may be made by contacting our Central Lab billing office at (801) 284-1184.)*
- *You elect to forfeit any financial assistance that may be available (excluding payment arrangements).*
- *If, at a later date, you request this account to be billed to your insurance, Intermountain Healthcare reserves the right to refuse that request.*

I hereby order Intermountain Precision Genomics to conduct the above test(s) and furnish the RxMatch service(s), which I have determined to be medically necessary. The medical necessity of the above test(s) and service(s), including navigation services, have been adequately documented in the patient's medical record. I have explained the risks, benefits and limitations of the above test(s) and service(s) to this patient, and have received informed consent from the patient, to the extent legally required, to permit Intermountain Precision Genomics to (i) perform the test(s) and service(s) specified herein, (ii) retain the test results for an indefinite period for internal quality/ operations purposes, (iii) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (iv) release the test results to the patient's third-party payer as needed for reimbursement purposes. I agree to provide Intermountain Precision Genomics with the information and documentation needed for Intermountain Precision Genomics to bill and collect for the above test(s) and service(s).

FOR OFFICE USE ONLY

Mail barcoded sample with this form to: Intermountain Precision Genomics Core Laboratory, 600 South Medical Center Drive St. George, UT 84790

Affix peelable barcode (matching to tube)

Order 50261

Patient Label