TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

ORDERING PHYSICIAN (Only fill out first line unless new customer or HCP# is unknown)

NAME (LAST, FIRST, DEGREE)

MYRIAD HCP ACCOUNT NO: (if known)

PATIENT ID # (OPTIONAL)

FEMALE

MALE

BIRTH DATE (MM/DD/YYYY)

NH #

E-MAIL ADDRESS:

ADDRESS

AUTHORIZED SIGNATURE

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein. By signing this form I attest that the patient meets the inclusion criteria stated in the Test Requested section above. Individual and treating physician have had a discussion prior to testing regarding the potential results of the test and determined to use the results to guide therapy.

HEALTHCARE PROVIDER’S SIGNATURE

DATE (MM/DD/YYYY)

BILLING/PAYMENT INFORMATION

OPTION 1: PLEASE BILL INSURANCE

For Medicare patients: only available if test order date is more than 2 weeks after discharge date

Include enlarged copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

OPTION 2: PATIENT PAYMENT

Please call Customer Service for questions regarding test prices

OPTION 3: OTHER BILLING

To establish an account, submit billing information with this form

MYRIAD GENETIC LABORATORIES, INC.

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