Rev. 4/27/2015

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Tax ID:95-1683875

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Phone 888-826-4362 Fax 626-301-8142
cmdl@coh.org http://cmdl.cityofhope.org

CMDL Insurance TRF

Patient Information

Last Name	First name	Middle Initial	Female Male	Date of Birth
Street Address, State, ZIP			Specimen Number or Code	Date Collected
Phone Number	Mother's Country or Region of Origin		Father's Country or Region of Origin	Ethnicity
Comments (note any consanguinity)		Marital Status: Single Married Divorced Separated Widowed		

ICD9 Codes (required for insurance):

Diagnosis / Clinical Findings / Family History (please attach the pedigree if available, completed Patient Information Form and/or clinic notes)

Patient history	Family history

Insurance information (please attach a clear copy of the front and back of the insurance card/cards)

Name of Insurance Policy Holder		Insured Social Security #	Insured Date of Birth	Relationship to Patient
Insurance Company Name	Insurance Company Address		Medicare Number	Medi-Cal Number
Insurance Company Phone			Insurance Group Number	Insurance Policy Number

Authorization # (If an authorization is available please attach a copy of it or attach a LMN for HMO insurances)

For insurance billing, please choose one of the following options for after insurance is approved

- ☐ **Hold the test and inform the MD/GC if the patient out-of-pocket cost is more than $250**
- ☐ **Start the test immediately**

Referring Physician and Genetic Counselor (or other contact) Information

Referring Physician Name		Referring Physician UPIN	Genetic Counselor (or other contact) Name and Title	
Referring Physician Phone	Physician Institution and Address		Counselor/Contact Phone	Contact Institution and Address
Referring Physician Fax			Counselor/Contact Fax	
Referring Physician Email*			Counselor/Contact Email*	

* Copy of results will be sent electronically via our secure system; email address also required for status updates

Tests Ordered (multiple tests are done simultaneously unless the order of reflexive testing is noted here)

Comment:

As the referring physician named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, has been offered genetic counseling as appropriate, and has satisfied the informed consent requirements of my institution.

Referring Physician Signature (required):________________________ **Date:** ____________

For laboratory use only	Kindred #:	Accession #:	Specimen Type and Amount:
	Comments:		