SPECIMEN KEY ON BACK

Quest Diagnostics™

Cardiology Genetics Requisition

BILL TO:
- ☐ My Account
- ☒ Insurance Provided
- ☐ Lab Card/Select
- ☐ Patient

PRINT PATIENT NAME (LAST, FIRST, MIDDLE): S H A R M A L A K S H Y A

REGISTRATION # (IF APPLICABLE): 1234567890

Date OF BIRTH: M M 03 D 01 D 2004 YEAR — SEX: M

PATIENT EMAIL ADDRESS: lakshya@email.com

PATIENT ID # / MRN: 1234567

DID YOU KNOW

IMPORTANT! THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY.

Each sample should be labeled with at least two patient identifiers at time of collection.

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

CELL PHONE: (555) 123-4567

PATIENT PHONE: (555) 123-4567

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT: S H A R M A L A K S H Y A

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #: 123 Elm Street, Springfield, IL 62704

CITY: S P R I N G F I E L D

STATE: IL

ZIP: 62704

ACCOUNT #: 1234567890
NAME: Lakshya
ADDRESS: 123 Elm Street, Springfield,
CITY, STATE, ZIP: IL 62704
TELEPHONE #: 1234567890

DATE COLLECTED: 10/13/2025

TIME: 10 : 02 ☒ AM ☐ PM

TOTAL VOL/HRS.: 12 ML 8 HR

☒ Fasting ☐ Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

Dr. John H. Reynolds, MD
NPI: 1456789321

INSURANCE

Primary Insurance ☐ Medicare ☐ Medicaid ☒ Other
Insurance Company Name: Springfield Health Mutual
ID #: SHM84920317 Group #: GRP5628
Insurance Address: 1500 Wellness Blvd, Springfield, IL 62704
Patient Is: ☒ Subscriber ☐ Spouse ☐ Other Dependent

Secondary Insurance ☐ Medicare ☒ Medicaid ☐ Other
Insurance Company Name: Illinois Medicaid Program
ID #: ILM43276891 Group #: —
Insurance Address: 201 State Center, Springfield, IL 62701
Patient Is: ☐ Subscriber ☒ Spouse ☐ Other Dependent

☒ ADDIT'L PHYS.: Dr. Emily Carter NPI/UPIN 1790543210

NON-PHYSICIAN PROVIDER: NAME: Sarah Thompson, PA-C I.D.#: 90877654

☒ Fax Results to: (555) 123-4567

Send Duplicate Report to: Client # OR NAME: Springfield Family Health Center
ADDRESS: 789 Oak Avenue
CITY: Springfield STATE: IL ZIP: 62704

ABN required for tests with these symbols

Medicare Limited Coverage Tests	@ = May not be covered for the reported diagnosis. F = Has prescribed frequency rules for coverage. & = A test or service performed with research/experimental kit. B = Has both diagnosis and frequency-related coverage limitations.	Provide signed ABN when necessary

Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines

ICD Codes (enter all that apply)

FOLD HERE

THIS REQUISITION MUST BE ACCOMPANIED BY THE CLINICAL HISTORY FORM.
FORM AVAILABLE THROUGH YOUR LOCAL REPRESENTATIVE OR BY VISITING WWW.QUESTCARDIOGENETICS.COM

Familial Hypercholesterolemia (FH)

94877 ☒ **Familial Hypercholesterolemia Panel**
(*LDLR, APOB, PCSK9* sequencing and deletion/duplication)

94878 ☐ **Familial Hypercholesterolemia Single site**
(Single site test can be ordered for *LDLR, APOB* or *PCSK9)*

Gene Name: LDLR Mutation Name: c.1060A>G (p.Asn354Ser)
NOTE: Copy of family member's report MUST be submitted.

For fastest processing, please fax this requisition and fully-completed Clinical History Form to 855.422.5181

If you have questions regarding this order, please call 866.GENE.INFO

REQUIRED SIGNATURES
PATIENT ACKNOWLEDGEMENT
I authorize Quest Diagnostics (Quest) to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance.

SIGNATURE REQUIRED

Patient Signature: Lakshya Sharma Date: 10/13/2025

STATEMENT OF MEDICAL NECESSITY AND INFORMED CONSENT
I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of disease, illness, impairment, symptom, syndrome, or disorder and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.

SIGNATURE REQUIRED

Medical Professional's Signature X: Dr. John H Reynolds Date: 10/13/2025

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

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SMOOTHSEAL®

Provide signed ABN when necessary

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

All samples to be shipped ambient, unless otherwise specified.

Specimen Key:	L	=	Lavender top tube

Consider taking advantage of our convenient scheduling. Visit us at QuestDiagnostics.com/appointment or call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile