Somatic Cancer Form

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

4978 Santa Anita Ave, Suite 205
Temple City, CA 91780
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info@FulgentGenetics.com

PRIMARY PATIENT

LAST NAME	FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ○ Male ○ Female ○ Unknown	
MED REC# / PATIENT IDENTIFIER	SPECIMEN DRAW DATE (MM/DD/YYYY)	
ADDRESS		
CITY	STATE / PROVINCE	POSTAL CODE
PHONE	EMAIL	
ETHNICITIES		

By signing below, I authorize Fulgent Genetics to utilize the submitted specimen and clinical information for genetic testing. I am giving Fulgent Genetics permission to use the specimen and information provided, without specifying identifying information, in publications by Fulgent Genetics. I agree to the selected billing notes detailed below. ☐ Opt out of research

PATIENT SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)

ORDER PROVIDER

INSTITUTION / PRACTICE NAME		INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME		PROVIDER FIRST NAME
NPI (USA)	MINC (CANADA)	PROVIDER TITLE (M.D., D.O., G.C.)
PROVIDER ADDRESS		
PROVIDER CITY	STATE / PROVINCE	POSTAL CODE
PROVIDER PHONE		FAX REPORT TO
GC / PRIMARY CONTACT NAME		CONTACT PHONE / FAX / EMAIL

By signing below, I, as the ordering Medical Provider, certify that the patients have 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 given their consent for genetic testing.

ORDERING PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)

TEST REQUESTED

Attach Detailed Medical Records and Clinical Notes

TEST NAME: Solid Tumor Molecular Profile

TEST SPECIFICS

PATIENT HISTORY

If previously tested at Fulgent, specify Accessionid: _____

Specify any transplant history: _____

Specify any therapy history: _____

Pathology Information

PATHOLOGIST NAME:

PATHOLOGIST NOTES:

CANCER TYPE AND STAGE: ○ Initial ○ Relapse

TISSUE SITE: ○ Primary ○ Metastatic

STATEMENT OF MEDICAL NECESSITY

By signing above, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

REQUEST FOR RELATED INFORMATION

Please send us a copy of any pathology or cytology reports along with test results from other genetic assays performed such as:

- Karyotype testing
- Previous genetic tests
- FISH results
- Histology tests
- Treatments including transplants
- Family history

INSURANCE BILLING

Attach Front and Back of all Insurance Cards, ABN, Medical Criteria Forms

☐ Use attached cards for billing ☐ Use below for billing	ICD-10 VALID CODE	REFERRAL/PRIOR AUTH #	FULGENT BENEFITS ID #	By signing above, the patient or insured authorizes Fulgent Genetics to release medical information concerning the test to the assigned insurance company.
PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

INSTITUTION / PRACTICE NAME		
ATTENTION TO		
ADDRESS		
CITY	STATE / PROVINCE	POSTAL CODE
PHONE	FAX/EMAIL	

SELFPAY BILLING

☐ Use patient information above for billing ☐ Use below for billing	By signing above, the patient or payor authorizes Fulgent Genetics to contact them directly, and use provided billing instructions to bill the indicated method.
PAYOR LAST NAME	PAYOR FIRST NAME
PAYOR ADDRESS	
PAYOR CITY / PAYOR STATE / PROVINCE / PAYOR POSTAL CODE	
PAYOR PHONE	PAYOR EMAIL

CLIA: 05D2043189
NPI: 1174964738