color

Test Requisition Form (Insurance)

Fax order to (650) 396-3046

GENETIC TEST*

Hereditary Cancer Test

*Please refer to color.com/learn/color-genes for a complete list of genes tested

PATIENT INFORMATION

Patient's first name	Patient's last name	Sex ◯ M ◯ F	DOB (MM/DD/YYYY)
Patient's address		City, state and zip	
Patient's email address **(required)**	Patient's phone number	MRN (optional)	

KIT INFORMATION

REQUIRED: BARCODE STICKER

Attach barcode from the Color kit. Please ensure the barcode is for the kit your patient used.

Sample collection date (MM/DD/YY)

PAYMENT INFORMATION

Insurance company name	Member ID	Policy holder's first and last name	
Relationship to policy holder ◯ Self ◯ Spouse/Partner ◯ Child ◯ Other	Credit card #	Expiration date	Security code

Family Testing Program (eligible for Hereditary Cancer Test only)

☐ This order is for Color's Family Testing Program	Patient's relation to the positive relative	Test results *Attach a copy of relative's positive test report*

ORDERING PROVIDER

☐ ☐ ☐ ☐

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Institution or practice		Address	
City, state and zip	Phone number	Fax number	Email address

ADDITIONAL RECIPIENTS (will receive copy of report)

Healthcare provider's name	Phone number	Fax number (for results delivery)	Email address

PATIENT'S PERSONAL HISTORY

Cancer/Tumor	Personal history	Age at Dx
Breast ☐ Triple negative (ER-, PR-, HER2-) ☐ Multiple primaries	◯ Yes ◯ No	
Ovarian ☐ Check if non-epithelial	◯ Yes ◯ No	
Prostate (Gleason score ≥ 7)	◯ Yes ◯ No	
Pancreatic	◯ Yes ◯ No	
Endometrial/Uterine	◯ Yes ◯ No	
Colon/Rectal	◯ Yes ◯ No	
Stomach	◯ Yes ◯ No	
Melanoma	◯ Yes ◯ No	
Other cancer(s):		
ICD-10 codes:		

OTHER PERSONAL INFORMATION

☐ Ashkenazi Jewish descent

☐ Bone marrow transplant recipient

☐ Previous genetic testing for hereditary cancer

☐ Current diagnosis of a hematologic cancer

FAMILY HISTORY OF CANCER

Relationship	Maternal or Paternal	Cancer site(s)	Age at Dx
	◯ ◯		
	◯ ◯		
	◯ ◯		
	◯ ◯		
	◯ ◯		
	◯ ◯		
	◯ ◯		
	◯ ◯		
ICD-10 codes:			

GENETIC COUNSELING ☐ In the case of a positive result, patient **does not** require genetic counseling by a board-certified genetic counselor at Color.

PATIENT RESULTS Color will automatically release results to your patient after 10 days. If you would like your patient to view their results earlier, you can manually release the results.

VUS DETAILS *In the event a Variant of Uncertain Significance (VUS) is identified, you and your patient will receive the technical details in the report. Place your order online with the Color Provider Platform to change this order setting.*

MEDICAL NECESSITY
Required for insurance

☐ I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient.

INFORMED CONSENT
If unchecked, patient must consent online using their Color account

☐ I attest that the patient has read the Color Informed Consent or had it read to him or her, and that I have fully informed the patient about the purpose, capabilities and limitations of the indicated Color genetic test. The patient has voluntarily given full consent for the indicated Color genetic test, and a signed copy of this consent is available on file. Any Color Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

Ordering physician signature _____ Date _____

By submitting this Test Requisition Form, I attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. If the patient's credit card information has been submitted, I also attest that the patient has authorized me to select the self-pay option and enter his or her payment information on his or her behalf. The patient has authorized Color and its designees to share the information on this form and related ordering information with his/her insurer for the purpose of processing, receiving payment, and appealing claims on behalf of the patient, and has agreed that any insurance payment sent directly to him/her will be remitted to Color within 30 days. The patient has also been informed that he/she shall be responsible for any co-pays, deductibles, and co-insurance, and any other amounts not paid by insurance. I agree to Color's transfer of the information in this form and the ordering physician's name to a Letter of Medical Necessity as authorization for insurance billing. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from Color. This genetic test and related services are governed by Color's Terms of Service, Notice of Privacy Practices, and Privacy Policy, and information provided on this Test Requisition Form is subject to Color's Privacy Policy and Notice of Privacy Practices, all of which are available at color.com or upon request.

F: (650) 396-3046 | P: (844) 362-6567 | providers@color.com

CLIA #05D2081492 - CAP #8975161

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