



REDUCED COST TESTING APPEAL FORM

Please note that by completing and submitting this form, you are requesting the Genetic Diagnostic Laboratory review your request for reduced cost testing and this request is still subject for approval, additional requested information or denial until the lab has confirmed the decision with you.

Patient Information:

FIRST NAME _____ MI _____ LAST NAME _____ BIRTH DATE (MM/DD/YYYY) _____ ASSIGNED SEX _____

Ordering Physician Information:

PHYSICIAN NAME _____ PHONE _____ FAX _____

EMAIL ADDRESS FOR PHYSICIAN _____ INSTITUTION AND DEPARTMENT _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

Reduced Price Appeal Requestor's relationship to patient (Please check one):

Doctor Genetic Counselor Family Member (Parent, child, etc.) Patient/ Self

Other: _____

Type of sample that will be submitted to complete testing (If you are unsure, please select which samples are options)

Blood Extracted DNA Saliva/ buccal Fresh/Frozen Tissue (Skin, Tumor, etc.) FFPE block/ scrolls

Other: _____

Full name of the ordered test: _____

Explanation of need for reduced cost testing

This could be related to financial need, insurance denial, etc.

See attached supporting document(s)

Medical necessity of ordered test for this patient

Please let us know why this testing is medically necessary for this patient and how the testing results impact clinical management.

****If requestor is not the patient's Doctor or Genetic Counselor this letter must be on official organization letter head with physicians' signature ****

See attached supporting document(s)

Completed Reduced Cost Testing Appeal Form can be emailed to the Genetic Diagnostic Lab for review and response.

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