Virant Diagnostics, Inc.
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Phone: (877) 888-2973, Fax: (888) 713-3456
CAP #: 954036801, CLIA #: 21D2184276
www.virantdx.com

Mast Cell Disorder Test Requisition Form

Place Barcode Label Here

Specimen Collection Information
Collection Date: ____ / ____ / _____
Collection Time: ____ : ____ ☐ AM ☐ PM

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:
Email:	Phone:	Gender: ☐ M ☐ F
Address:	City: State:	Zip:

DIAGNOSIS CODES

*For **Alpha-tryptasemia CNV**, please select the code below and include it in the provider's notes:* ☒ D89.44: Hereditary alpha tryptasemia (HaT)	*For **High Sensitivity KIT D816V Mutation Hotspot**, please select the appropriate code below and include it in the provider's notes:* ☐ D47.02: Systemic Mastocytosis (SM) ☐ C96.20 Malignant mast cell neoplasm, unspecified (*Use in place of D47.02 for Medicare patients*)

Additional Codes:

PATIENT CONSENT/AUTHORIZATION

My healthcare provider has recommended that I receive genetic testing, and I authorize Virant Diagnostics to analyze my (or my child's) blood or saliva samples for such tests ordered. My healthcare provider has explained to me the genetic tests, their limitations, and that the purpose of the tests is to look for mutations or genetic alterations. Test results will only be released to healthcare providers as specified on the test requisition form. Furthermore, I authorize Virant Diagnostics to submit claims to my healthcare insurers for the lab services provided. I also authorize Virant Diagnostics and my healthcare provider to release any medical information necessary to the insurers to process this claim. Payment will be made directly to Virant Diagnostics from my insurers. If my insurers pay me directly, I agree to forward the payment to Virant Diagnostics. I understand that I am responsible for any amounts not covered or paid by my insurers. Should there be no insurance coverage, Virant Diagnostics reserves the right to bill me directly. I acknowledge that I have read and understood the Genetics Informed Consent Form at https://virantdx.com/wp-content/uploads/2022/12/Genetics-Informed-Consent-Form-221212.pdf.

Signature: _____ **Date:** ____ / ____ / _____

Printed Name: _____ **Relationship:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Durable Power of Attorney for Health Care

INSURANCE AND PAYMENT INFORMATION

☐ **Bill Insurance** (Attach copy of insurance card, front and back)

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:
☐ **Bill Client** (Based on prior agreement)	☐ **Bill Patient** (Based on prior agreement)

HEALTHCARE PROVIDER INFORMATION

Provider Name:		NPI:	
Organization:		Phone:	
Address:	City:	State:	Zip:

Provider Authorization Signature: _____ **Date:** ____ / ____ / _____

MAST CELL DISORDER TESTS

Specimen Collection and Shipment Requirements: *At least 3 mL of **whole blood** must be collected in an EDTA tube (lavender top) and sent to the laboratory on the day of collection for next day delivery. The specimen must be stored at 4°C until shipment and shipped with an ice pack.*

☐ **Mast Cell Disorder Genetic Panel**: *Order as a panel or an individual test*

- ☐ **High Sensitivity KIT D816V Mutation Hotspot**: dPCR detection of the most common systemic mastocytosis-causing mutation, KIT D816V
  Test Sensitivity: 0.005%; Reportable: 0.015% mutated alleles
- ☐ **Alpha-tryptasemia Copy Number Variation**: dPCR detection of copy number variations of the TPSAB1 gene on the tryptase locus

Please see reverse side for ordering instructions.

ORDERING INSTRUCTIONS

1. For clinics and providers new to Virant Diagnostics, contact us at MCDlab@virantdx.com or (877) 888-2973 for more details on how to complete the test requisition, either on paper through this form or online through our Laboratory Information System (LIS).
2. After completing the test requisition, arrange specimen collection or phlebotomy services and prepare the specimen for shipment. Include the test requisition form, the patient's medical records (provider's notes, prior laboratory results, etc.), and an insurance card copy (front and back). These documents can also be uploaded to the patient's Documents in our LIS or faxed to (888) 713-3456.
3. Once the specimen is received, prior authorization will be requested by Virant Diagnostics on the provider and patient's behalf. The outcome will be communicated to the provider and patient before the specimen is processed.

Please visit our webpage at https://virantdx.com/testing-solutions/genetic-testing/mcd/
and contact us at MCDlab@virantdx.com or (877) 888-2973 for any inquiries.

FOR LABORATORY USE ONLY

Accession #:		Patient ID:
Client/Physician ID:	Date Received: ____ / ____ / _____	Time Received: ____ : ____ ☐ AM ☐ PM
Comment:		