Colorado Genetics Laboratory

Requirements for Culturing and Shipping
Specimens to Other Laboratories

Before sending a specimen to the Colorado Genetics Laboratory for cell culture and shipment to another laboratory for testing, please read the following information:

1. **Complete a Colorado Genetics Laboratory *Information for Referral Specimens* form**
   - ❖ Include complete information about where the specimen is to be sent
   - ❖ The report of the referral lab's results will be sent directly to you. Please be sure that your name and address are complete on the form.
   - ❖ The *Information for Referral Specimens* form must accompany the specimen to our laboratory and will be forwarded to the referral lab.
   - ❖ If you are requesting that cells be shipped to more than one laboratory, please complete an *Information for Referral Specimens* form for each outside laboratory.

2. **Complete a *Patient Health Insurance Waiver* form**
   - ❖ This waiver does not apply to Medicaid patients or shipping charges billed to a hospital/facility.
   - ❖ Insurance does not generally cover shipping charges; therefore, it is the patient's responsibility and must be prepaid.

3. **Charges from the referral laboratory cannot be billed to the Colorado Genetics Laboratory.** Please make arrangements with the referral laboratory for their charges to be billed to the patient, insurance, or your facility, as appropriate.

4. In most cases, cells are ready for shipping 10-14 days after receipt in our laboratory.
   Please be advised of the following:
   - ❖ If we do not have the completed *Information for Referral Specimens* form(s), a signed *Patient Health Insurance Waiver*, and payment for each shipment when the cells are ready for shipping, the cells will be frozen and maintained at the Colorado Genetics Laboratory for 2 years.
   - ❖ You may then provide the required information, forms, and/or payment and request that the cells be thawed, re-cultured, and sent for testing. This will incur additional charges.

If you have any questions regarding culturing and shipping cells,
please call the Colorado Genetics Laboratory at 303-724-5701.

Forms are available on our website at www.coloradogeneticslab.com

Revised 10/15/2012

INFORMATION FOR REFERRAL SPECIMENS

Colorado Genetics Laboratory
12705 E. Montview Blvd., Suite 400
Denver, Colorado 80238
303-724-5701
888-659-4932 Toll Free
303-724-5795 Fax

CGL Accession No. ____________________

Patient Information

Patient Name ____________________ Birthdate ____________

Procedure Date ____________ Type of Specimen ____________________

Medium Used ____________________

Send Results to

Referring Physician ____________________

Address ____________________

____

Phone No. ____________________ Fax No. ____________________

Billing Information

Charges for this test cannot be billed to the Colorado Genetics Laboratory.

I have spoken to ____________________ at the laboratory below and understand that:

a. The charges for this test are $ ____________
b. The charges for this test will be billed to ____________________

My signature below indicates agreement with the above billing arrangements and testing information

____

Referring physician or designee *Date*

Referral Laboratory Information

Test Requested ____________________

Specimen Requirements ____________________

____

Send uncultured specimen in addition to cultured cells? No Yes Amount ____________

Send Specimen(s) To ____________________

Address ____________________

____

Phone No. ____________________ Fax No. ____________________

Contact Person ____________________

Other Information ____________________

Attach referral lab forms (required), patient history and/or cover letter to this form.

To Be Completed by CGL:

Date uncultured specimen sent ____________

Date cultures sent ____________

Number of flasks sent ____________

CGL contact person ____________

Medium used ____________

Passage level ____________

Cells frozen No Yes

Revised 4/2016

CU MEDICINE

PATIENT NAME (PRINT): ______________________________

PATIENT DATE OF BIRTH: ______________________

PATIENT HEALTH INSURANCE WAIVER

<u>This Waiver Does Not Apply to Medicaid Patients</u>

<u>This Waiver Does Not Apply to Charges Billed to a Hospital or Facility</u>

- I have requested services provided by a provider at the University of Colorado Denver School of Medicine.
- I understand that these services will be billed by CU Medicine.
- I further understand I am responsible for all charges for the specimen collected on _______________ for CPT code 99001 - handling and/or conveyance of specimen for transfer from the patient to a laboratory - by (providers) Liming Bao, PhD, Karen Swisshelm, PhD, or Mary Haag, PhD.
- Self-pay charge for CPT code 99001: $40.00 per shipment, whether local or long distance
- CPT Code 99001 must be prepaid. Specimens will not be shipped without prepayment and a signed Patient Health Insurance Waiver.
- **Complete and sign this waiver, and include a check made payable to CU Medicine for $40.00 for <u>each</u> shipment.**

____

Patient Signature (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)

____ **Date** ____________________

Printed Name and Relationship of Person Authorized to Sign for Patient

____

Reason Patient is Unable to Sign

Insurance Waiver Explained by: ____

(Printed Name of Hospital, Physician, or CU Medicine Representative)

____ **Date** ____________________

Signature of Hospital, Physician, or CU Medicine Representative

Revised: October 2018