Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

Patient Name: **Identification Number:**

Notice of AHCCCS Non-Coverage

According to our understanding of AHCCCS and/or your Health Plan's coverage rules, we believe the tests marked below and requested by your physician are not eligible for coverage by the AHCCCS program or your Health Plan because the tests are excluded by statute or rule.

Medical Policy for AHCCCS Covered Services - Chapter 300 (310-31):

- Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases.
- Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

We are notifying you of this non-coverage in advance of providing the testing (pursuant to Arizona Administrative Code R9-22-702(D)), so you can decide if you still want to have the testing done. If you choose to have the testing done, you will be billed for the tests directly.

Test Code	Test Name	Patient Price
☐ 906369	BRCAvantage™, Comprehensive	$ 2,495.00
☐ 906366	BRCAvantage™, Ashkenazi Jewish Screen	$ 500.00
☐ 906367	BRCAvantage™, Rearrangements	$ 500.00
☐ 906368	BRCAvantage™, Single Site	$ 500.00
☐ 906474	BRCAvantage™, Ashkenazi Jewish Screen w/Reflex to BRCAvantage™ Comprehensive	$ 500.00 ($2,995.00 with potential reflex)

What You Need To Do Now:

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Choose an option below about whether to receive the test(s) marked above

Check only one box. We cannot choose a box for you.

☐ **1.** ***I want the test(s) marked above*** and I agree to accept the financial responsibility and pay for the test(s) myself.

☐ **2.** ***I do not want the test(s)*** marked above.

Additional Information: If you choose not to sign this notice, we will not perform the testing requested by your physician. You should notify your physician that you did not have the testing done.

Signing below means that you have received and understand this notice, that you have had an opportunity to ask questions, that you are accepting financial responsibility and that you agree to pay Sonora Quest Laboratories for the test(s) marked above.

You also will receive a copy of this notice.

Signature:	**Date:**