MNG LABORATORIES
A LabCorp Company

WES & WGS Data Reanalysis Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 678.225.0222 | fax: 678.225.0212 | mnglabs.labcorp.com

Applies to data generated at Labcorp only

Full data reanalysis is available 12 months after initial report, and once per 12 month period thereafter. After the initial reanalysis, subsequent reanalysis requests will be billed - please include billing information.

All data, including copy number changes and identified variants, will be re-evaluated. Variants may be identified that were not previously reported due to updated available information. An updated report will be issued with each request, whether or not any changes have been identified. Please include any new clinical information or additional testing that has been performed for the patient or family members.

Reanalysis for next-generation sequencing is limited to data generated at the time of initial testing.
Changes and improvements to technologies may not be available for reanalysis with previous versions of our assays.

Please complete this form in its entirety and send back to MNG via fax 678-225-0212 or email to MNGSupportServices@labcorp.com.

Patient and Report Information

Patient Last Name	Patient First Name
Patient ID #	Date of Birth [MM/DD/YYYY]
Gender ☐ Male ☐ Female	Date of Testing [MM/DD/YYYY]

REQUIRED INFORMATION

MNG ID# / Accession #: _____

Original Test ☐ Exome ☐ Genome

Please indicate reanalysis type:

☐ First Reanalysis (no cost)

☐ Second or Subsequent Reanalysis

Date of previous request: _____

Referring Physician Information

Are You The Referring Physician? ☐ Yes ☐ No *(if no, please include medical record release)*

Physician Name	NPI # or equivalent *(Required)*
Facility / Organization	Signature
Facility Address City, State, Zip Code	
Report Delivery ☐ Fax ☐ Email	Phone

Results

Authorized Recipient Name	Authorized Recipient Name
Facility Phone	Facility Phone
☐ Fax	☐ Fax
☐ Email	☐ Email

Billing Information *(REQUIRED)*

Self-Pay? ☐ Yes If yes, **MUST** include payer contact name & details below. Payment must be received in full prior to testing.

Facility	Contact Name
Billing Address	
City, State, Zip Code	
Phone Fax	Email