BLUE CROSS PERSONALIZED MEDICINE℠ PROGRAM
TEST REQUISITION FORM

To access test results, create an account at MyRightMed.com/BCBSM-providers

Include completed form with your sample or fax back to (866) 769-8066

PATIENT INFORMATION

First name

Last name

Sex
○ M ○ F

Date of birth

BCBS Patient ID #

Phone

Email

Ethnicity

- ○ American Indian or Alaska Native
- ○ Ashkenazi Jewish
- ○ Black / Sub-Saharan African / African American
- ○ Central / South Asian
- ○ East Asian
- ○ First Nation / Inuit / Metis
- ○ Hispanic or Latino
- ○ Native Hawaiian or Other Pacific Islander
- ○ Near / Middle Eastern
- ○ Sephardi Jewish
- ○ White or Caucasian
- ○ Unknown / Not Provided

Street address

City

State

Zip code

Country

Not every patient or BCBSM member is eligible for a RightMed® test at no-cost. Please confirm patient eligibility for this program.

View your full list of eligible patients in your portal account at:
MyRightMed.com/BCBSM-providers

PRACTICE INFORMATION

Institution name

Street address

City

State

Zip code

Country

Phone

Fax (for results)

Ordering provider name

Ordering provider NPI #

Ordering provider email (for report access)

AUTHORIZATION

By completing this order, I certify that I am the ordering provider, I am authorized by an ordering provider to order this test, or I am authorized under applicable state law to order this test. I further certify that I have received the OneOme informed consent (***oneome.com/informed-consent***) conveyed all required information to the patient (or legal guardian), and have obtained his or her consent for this test order. The patient has further been informed and hereby authorizes OneOme and its designees to release information concerning testing to their insurers in order to process and/or appeal claims on behalf of the patient. For amounts received directly, the patient agrees to remit payments to OneOme for testing services rendered. I agree to OneOme's terms of service (***oneome.com/terms***) and privacy policy (***oneome.com/privacy***).

Ordering provider signature

Date

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