

Test Requisition Form

ORDERING INSTRUCTIONS

1. Complete ALL fields below (missing information will result in delay of testing)
2. Attach patient face sheet and copy (front and back) of insurance card(s) and pathology report for the specimen requested in Section V
3. Ship with specimen to Biotheranostics' laboratory OR fax this form to 800-266-9607 and Biotheranostics will request the specimen from Pathology.

INFORMATION ON THIS FORM MUST BE ACCURATE TO OBTAIN RELIABLE TEST RESULTS

I. TEST REQUESTED

 The CancerTYPE ID® Test

Molecular diagnosis of tumor type & subtype

SPECIAL INSTRUCTIONS:

Check below if you would like the sample sent to our partner laboratory, NeoGenomics Laboratories for additional testing*

 Cancer Profile and Biomarker Testing Based on CancerTYPE ID Result NEO PanTracer™ Tissue Add a 22C3 PD-L1 clone with CPS and TPS scoring I authorize all NeoGenomics testing associated with this CancerTYPE ID order to be accessioned to my NeoGenomics account number:

*Visit Neogenomics.com for details on additional testing associated with CancerTYPE ID test molecular diagnoses. Additional testing will be reported and billed separately by NeoGenomics.

**Note: If a Cancer Profile and Biomarker Testing, and NEO PanTracer Tissue Testing are both selected, only the NEO PanTracer Tissue Testing will be performed.

II. ORDERING PHYSICIAN/PRACTITIONER

Specialty: Oncology Pathology Surgery Other:

Name

NPI

Email

Practice/Facility Name

Phone

Fax

Address

City

State

Zip Code

III. PATHOLOGY FACILITY (Facility that will release the specimen for testing)

Name

NPI

Email

Practice/Facility Name

Phone

Fax

Address

City

State

Zip Code

 Please return the specimen to the location listed above once testing complete Please return the specimen to alternate location listed below:
Address:

Phone:

IV. PATIENT INFORMATION

Please include a copy of the patient face sheet

Name

Date of Collection

DOB

Sex M F

Address

City

State

Zip Code

Phone

Next Appt. Date / /

VI. BILLING INFORMATION

Please include a copy (front and back) of patient insurance card(s)

Bill to: Patient HMO IPA PPO
 Hospital/Facility Medicare Advantage Medicare* (complete section VII)

Prior Authorization Required? Yes - Prior Authorization # _____
 No

VIII. PHYSICIAN/PRACTITIONER CERTIFICATION

I hereby request and authorize Biotheranostics to utilize the above information to process the tumor specimen for the indicated patient. I certify the following: I am authorized by law to order the test(s); the tests ordered above are medically necessary; the results will be used in the management of the patient; and I have obtained any required patient consent for performing the test(s) and disclosure of test results to me as the ordering physician and to the pathologist(s) providing the testing specimen. I agree to provide the necessary information and records needed for billing or reimbursement of the test(s). I have read the reverse side for additional details.

Signature _____

Printed Name _____

Date _____

V. SPECIMEN INFORMATION

Reminder: Has pathologist reviewed tissue for adequacy? Yes No

Specimen ID

Biopsy Site

Clinical Diagnosis

Fixative Type (Recommended 10% Neutral-Buffered Formalin)

ICD-10 Codes - Select all codes that may apply from the list of commonly used codes below; if other, please list the code(s) with the greatest specificity in the space provided

C80.1 - Malignant (primary) C80.0 - Disseminated malignant neoplasm, unspecified C79.51 - Secondary malignant neoplasm of bone
 C78.7 - Secondary C22.9 - Malignant neoplasm of liver not specified as primary or secondary Other (see cancertypeid.com for list of ICD-10 codes covered by Medicare*):

VII. REQUIRED FOR MEDICARE*

Medicare Status - Check box for patient's hospital status when sample was obtained:

Hospital Inpatient: Date of Discharge _____
 Hospital Outpatient

* See cancertypeid.com for details of Medicare LCD coverage criteria

