

COLOGUARD® ORDER REQUISITION FORM

Stool-based DNA test with hemoglobin immunoassay component

EXACT SCIENCES LABORATORIES, LLC

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Provider & Order Information Recommended: type all Provider information. Editable, printable PDF available at exactlabs.com	
PROVIDER INFORMATION	ORDER INFORMATION
Healthcare Organization Name:	This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.
Provider Name:	ICD-10 Code:
NPI #:	O Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])
Location Address:	Other(s) Certification
City, State, Zip:	I am a licensed healthcare provider authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect additional samples from the patient as appropriate.
Phone Number:	
Secure Fax Number*: *To receive results for this order, please provide secure FAX number only	Ordering Provider Signature Date of Order
Patient Demographics Attach a copy of the front & back of primary and/or secondary insurance cards.	
Patient ID/MRN:	Phone Number (required):
First Name: Last Name:	O Home O Mobile O Work
DOB (mm/dd/yyyy): Sex: O Male O Female	Language Preference (optional):
Shipping Address:	Billing Address:
City, State, Zip:	City, State, Zip:
PATIENT ETHNICITY AND RACE The completion of this section is optional.	
Is your patient of Hispanic or Latino origin or descent? O Yes O No	
Please mark one or more to indicate your patient's race: White Black or African-American Asian Native Hawaiian or other Pacific Islander American Indian or Alaska Native	
Patient Insurance/Billing Information Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.	
Does patient wish Exact Sciences to bill their insurance? OYes (complete below) ONo (patient will self-pay)	
Policyholder Name: Policyholder DOB: Relationship to patient: O Self O Spouse O Other	
Primary Insurance Carrier: Type: O Private O Medicare O Medicare Advantage O Medicaid O Tricare	
Claims Submission Address:	
Subscriber ID/Policy Number: Group Number: Plan: Plan:	
Prior-Authorization Code (if available):	
PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES	
I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan and furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to Exact and authorize Exact to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider. I further understand that if I am a Medicaid enrollee in a state where Exact is enrolled as a Medicaid provider, Exact will accept as payment in full the amounts paid by the Medicaid program, plus any deductible, coinsurance or copayment which may be required by the Medicaid program to be paid by me. Patient Signature: Date:	