cologuard®
Rx only

Appointment Date:

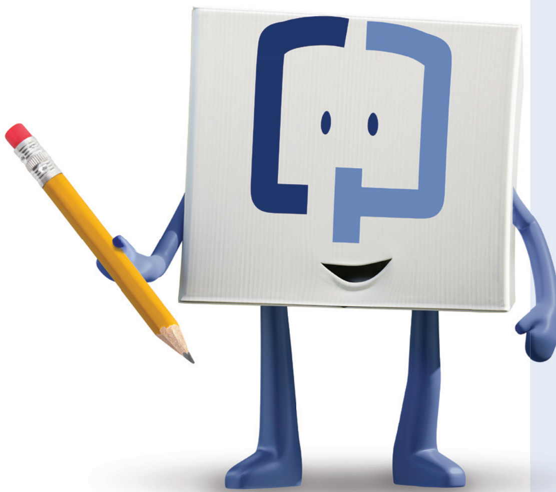
DISCUSSION GUIDE

LET'S *talk.*

If you're 50 years of age or older, you know it's time to talk to your doctor about colon cancer screening. Cologuard is a new, noninvasive, test that uses the DNA in your stool to find colon cancer. It requires no special preparation, no time off and it's easy-to-use at home!

Print this Discussion Guide and take it to your next doctor's appointment.

Include your full medical history when discussing the following questions. Ask if Cologuard is the best screening option for you.



ANSWER *this:*

Have you ever been screened for colon cancer?
___Yes ___No

Have you been avoiding a colonoscopy?
___Yes ___No

ASK *this:*

___What are my risk factors for colon cancer? What are the symptoms?

___What are my screening options? How do they differ?

___Is Cologuard right for me?

Healthcare Providers

Ready to order Cologuard? Visit **www.CologuardTest.com** to download an order form today. To learn more or contact us, call **1-844-870-8870**.

EXACT SCIENCES CORPORATION
441 Charmany Drive, Madison, WI 53719
www.ExactSciences.com | www.ExactLabs.com | 1-844-870-8870
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exact sciences

COLOGUARD® ORDER REQUISITION FORM

EXACT SCIENCES LABORATORIES, LLC
145 E. Badger Rd, Ste 100, Madison, WI 53713
P: 844-870-8879 | www.exactlabs.com
Fax completed form to 844-870-8875

Provider & Order Information

Recommended: type all Provider information.
Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization: ______________________________

Provider Name: ______________________________

NPI #: | | | | | | | | | | |

(or DEA # if NPI is not available)

Location Address: ______________________________

City, State, Zip: ______________________________

Phone Number: ______________________________

Secure Fax Number*: ______________________________

*To receive results for this order, please provide **secure** FAX number only

TEST INFORMATION

Test Name: Cologuard

Test Description: Stool-based DNA test with hemoglobin immunoassay component

ICD-10 Code:

Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

Other(s) ______________________________

We will not ship a collection kit to the patient if ICD-10 coding is missing. The above code is listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.

Certification

I am a licensed medical professional 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 a second sample from the patient as appropriate.

____

Ordering Provider Signature **Date of Order**

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan & furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights & benefits under my insurance plans to Exact & authorize Exact to appeal & 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.

Patient Signature: ______________________________ **Date:** ______________

Patient Information

Attach a copy of the front & back of primary and/or secondary insurance cards.

PATIENT INFORMATION: *Recommended – also attach a patient demographic sheet*

Patient ID/MRN: ______________________________

First Name: ______________ Last Name: ______________

DOB* (mm/dd/yyyy): ___/___/_______ Sex: Male Female

*Medicare/Med Advantage coverage for patients between ages 50-85

Phone Number *(required)*: ______________________________

Home Mobile Work

Email address: ______________________________

Language Preference *(optional)*: ______________________________

PATIENT ADDRESS

Shipping Address: ______________________________

____

City, State, Zip: ______________________________

Billing Address: ______________________________

Same as Shipping

____

City, State, Zip: ______________________________

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.

Policyholder Name: ______________ **Policyholder DOB:** ___/___/_____ **Relationship to patient:** Self Spouse Other

Type: Insurance Medicare Medicare Advantage Medicaid Tricare Self-Pay

Insurance Carrier/Program: ______________________________ **Customer Service # on Insurance Card:** ______________

Claims Submission Address: ______________________________

Subscriber ID/Policy Number: ______________ **Group Number:** ______________ **Plan:** ______________

Fax completed form to 844-870-8875

For Laboratory Use Only
Sample Collected: __/__/_____
Sample Received: __/__/_____