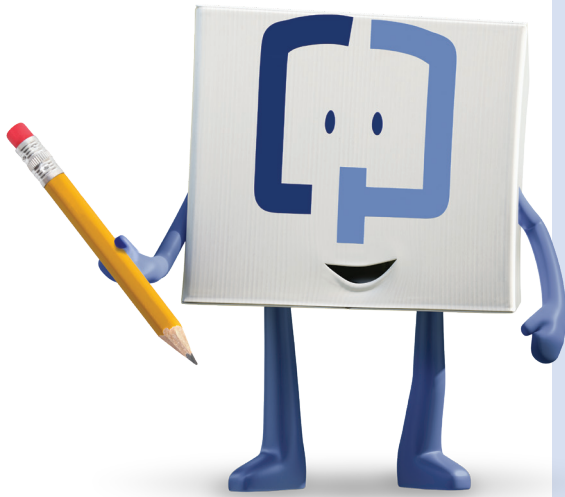

DISCUSSION GUIDE

LET'S *talk.*

If you're 50 years of age or older, you know it's time to talk to your healthcare provider about colon cancer screening. Cologuard® is a noninvasive test for average risk patients that uses the DNA in your stool to detect colorectal 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 to your next healthcare provider appointment.

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



ANSWER *this:*

Have you ever been screened for colon cancer?

Yes No

Have you been avoiding screening?

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

Cologuard is intended for the qualitative detection of colorectal neoplasia associated DNA markers and for the presence of occult hemoglobin in human stool. A positive result may indicate the presence of colorectal cancer (CRC) or advanced adenoma (AA) and should be followed by diagnostic colonoscopy. Cologuard is indicated to screen adults of either sex, 50 years or older, who are at typical average-risk for CRC. Cologuard is not a replacement for diagnostic colonoscopy or surveillance colonoscopy in high risk individuals.

Cologuard is not for high risk individuals, including those with a history of colorectal cancer and advanced adenoma, a family history of colorectal cancer, IBD or certain hereditary syndromes. Positive Cologuard results should be referred to diagnostic colonoscopy. A negative Cologuard test result does not guarantee absence of cancer or advanced adenoma. Following a negative result, patients should continue participating in a screening program at an interval and with a method appropriate for the individual patient. Cologuard performance when used for repeat testing has not been evaluated or established. Rx only.

EXACT SCIENCES CORPORATION

441 Charmany Drive, Madison, WI 53719
ExactSciences.com | ExactLabs.com | 1-844-870-8870

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US.CG.1779-1-May 2019

Provider & Order Information

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

PROVIDER INFORMATION

Healthcare Organization Name: _____

Provider Name: _____

NPI #:

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

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

ORDER INFORMATION

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.

ICD-10 Code:

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

Other(s) _____

Certification

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.

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: _____

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): _____ Sex: Male Female

Shipping Address: _____

City, State, Zip: _____

Phone Number (required): _____
 Home Mobile Work

Language Preference (optional): _____

Billing Address: _____
 Same as Shipping

City, State, Zip: _____

PATIENT ETHNICITY AND RACE

The completion of this section is optional.

Is your patient of Hispanic or Latino origin or descent? Yes 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? Yes (complete below) No (patient will self-pay)

Policyholder Name: _____ Policyholder DOB: _____ Relationship to patient: Self Spouse Other

Primary Insurance Carrier: _____ Type: Private Medicare Medicare Advantage Medicaid Tricare

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ Group Number: _____ 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: _____

Fax completed form to 844-870-8875

For Lab Use Only

Sample Collected: ___/___/___ Sample Received: ___/___/___