nodify xl2™ PROTEOMIC TEST

Phone: **1.866.432.5930** | Fax: **1.866.432.3338**
Email: **custcare@biodesix.com**

ATTACH PATIENT ID LABEL HERE
(With Name, Date of Birth, and Draw Date)

Test Request Form

PATIENT INFORMATION (REQUIRED)

Patient Last Name:	Patient First Name:	
Address:		
City:	State:	Zip Code:
Date of Birth: Date (MM|DD|YYYY):	Gender:	Phone:

PATIENT CHARACTERISTICS (REQUIRED)

Nodule Diagnosis (ICD-10 Code):	Nodule located in upper lobe? ☐ Yes ☐ No
Nodule Diameter (mm):	Nodule Spiculated?* ☐ Yes ☐ No

Smoking Status:
☐ Current ☐ Former ☐ Non-Smoker

Does the patient have a history of cancer?
☐ Lung Cancer ☐ Non-Lung Cancer ☐ No History of Cancer

If patient has a history of cancer, please indicate date of previous diagnosis:

* Spiculation indicates that the nodule of concern has non-smooth edge characteristics. Other terms commonly used include "stellate" and "irregular".

BILLING INFORMATION (REQUIRED)

Check Only One Box

☐ **Patient insurance information is ATTACHED** (Please attach a copy of the patient's insurance card and/or Face Sheet if possible)

☐ **Patient does not have insurance** (please complete the financial assistance application included in test kit and attach a copy)

Nodify XL2 uses CPT code 0080U for billing purposes

DIAGNOSTIC PLAN (IF APPLICABLE)

Prior to receiving test results, which procedures are you considering for this patient (check all that apply)

☐ Follow-up CT or LDCT
☐ PET
☐ **Bronchoscopy** (type of Bronchoscopy):
☐ **Needle Biopsy** (type of Needle Biopsy):
☐ Surgery
☐ **Other** (please specify):

Date of Procedure (if scheduled):

PHYSICIAN INFORMATION (REQUIRED)

Office | Practice:		
Ordering Physician:		
Address:		
City:	State:	Zip Code:
Office | Practice Primary Contact:	Phone:	Fax:
Office | Practice Secondary Contact:	Phone:	Fax:

Test Result Delivery: ☐ Encrypted Email ☐ Fax ☐ Copy Secondary Contact ☐ Physician Portal

Email:

By checking any of these test delivery options, you are authorizing the electronic delivery of test results by Biodesix in accordance with the Health Insurance Portability and Accountability Act and the rules reflected in the HITECH Act.

BLOOD DRAW INSTRUCTIONS (REQUIRED)

Select the location of blood draw

☐ Ambulatory Surgery Center
☐ In Office (non-hospital)
☐ Independent Lab (enter name):
☐ Hospital (inpatient)
☐ Hospital (outpatient)
☐ Independent Phlebotomist (enter name):

☐ Coordinate Home Phlebotomy (**Please fax this form to 1.866.432.3338**)

For Phlebotomist Use Only

☐ I, the phlebotomist, verify that the enclosed specimen was collected and processed according to the protocol provided by Biodesix. I verify that this specimen is the specimen taken from the patient named on this form.

Initial: Date (MM|DD|YYYY):

AUTHORIZATION AND CERTIFICATION OF MEDICAL NECESSITY (REQUIRED)

Your signature constitutes a certification of medical necessity and intent to consider and use the results of the test(s) ordered. All of the information on this form is true and correct. You have obtained patient consent and authorize Biodesix to use and release the results and patient information for reimbursement purposes and as may be appropriate for additional clinical testing services.

Signature of treating physician or authorized representative. Date (MM|DD|YYYY):

Medicare Signature Requirements for providers define a valid signature as "handwritten or electronic. Please provide a wet ink or electronic signature on this form. If you are unable to do so, please contact Biodesix Customer Care at 1.866.432.5930.

INTERESTED IN ONLINE ORDERING AND TEST DELIVERY?

Contact Customer Care at 1.866.432.5930 to learn more about the Biodesix Physician Portal.

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