biodesix lung REFLEX

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 (MM|DD|YYYY):	Gender:	Phone:

PATIENT CHARACTERISTICS (REQUIRED)

Cancer Diagnosis (ICD-10 code):

EGFR Sensitizing Mutation Status:
☐ Positive ☐ Negative ☐ Unknown

If Cancer Diagnosis is not available, please indicate scheduled date of diagnostic procedure (MM|DD|YYYY):

ECOG Performance Status: (if known)
☐ ECOG 0
☐ ECOG 1
☐ ECOG 2
☐ ECOG 3
☐ ECOG 4

Histology: (if known)
☐ Adenocarcinoma
☐ Squamous
☐ Other

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)

VeriStrat uses CPT code 81538 for billing purposes. GeneStrat uses CPT codes 81479 (ALK), 81210 (BRAF), 81235 (EGFR), 81275 (KRAS), 81479 (ROS-1 & RET) for billing purposes.

TEST MENU (REQUIRED)

Select the box next to Biodesix Lung Reflex to order the full test offering, or check any of the individual options below to order tests individually

☐ **Biodesix Lung Reflex® Tests**
GeneStrat® genomic test (all mutations) will reflex to VeriStrat® proteomic test

☐ **VeriStrat® Proteomic Test Only**

☐ **GeneStrat® Genomic Test Only** (all mutations)

Or check individual markers to test specific mutations:

☐ EGFR sensitizing ☐ EGFR resistance (T790M)
☐ ALK ☐ ROS1 ☐ RET ☐ KRAS ☐ BRAF

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
☐ Copy Secondary Contact
☐ Fax
☐ Physician Portal

Email Address:

By selecting 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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