

**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: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
If Cancer Diagnosis is not available, please indicate scheduled date of diagnostic procedure (MM DD YYYY):	
ECOG Performance Status: (if known)	Histology: (if known)
<input type="checkbox"/> ECOG 0 <input type="checkbox"/> ECOG 3 <input type="checkbox"/> ECOG 1 <input type="checkbox"/> ECOG 4 <input type="checkbox"/> ECOG 2	<input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Squamous <input type="checkbox"/> 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 81235 (EGFR), 81401 (ALK), 81404 (RET), 81479 (ROS1), 81275 (KRAS), and 81210 (BRAF) for billing purposes.

TEST MENU (REQUIRED)

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

Biosesix 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:	<input type="checkbox"/> Encrypted Email <input type="checkbox"/> Fax <input type="checkbox"/> Copy Secondary Contact <input type="checkbox"/> Physician Portal	
Email Address:		

By selecting any of these test delivery options, you are authorizing the electronic delivery of test results by Biosesix 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 Hospital (inpatient)
 In Office (non-hospital) Hospital (outpatient)
 Independent Lab (enter name): 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 Biosesix. 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 Biosesix 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 Biosesix 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 Biosesix Physician Portal.