EXACT SCIENCES LABORATORIES

COLOGUARD® ORDER REQUISITION FORM

Stool-based DNA test with hemoglobin immunoassay component

EXACT SCIENCES LABORATORIES, LLC
145 E Badger Rd, Ste 100, Madison, WI 53713
p: 844-870-8870 | ExactLabs.com
NPI: 1629407069 TIN: 463095174

Provider & Order Information

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

PROVIDER INFORMATION

Healthcare Organization Name: Health Care

Provider Name: NOBEL CHEM

NPI #: 5 8 9 2 3 1 5

Location Address: MALAD WEST

City, State, Zip: 02115

Phone Number: 1542367890

Secure Fax Number*: NAHIO

*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 05/04/20 ***Date of Order***

Patient Demographics

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

Patient ID/MRN: 23110LK

First Name: DaMN Last Name: John

DOB (mm/dd/yyyy): 03/02/98 Sex: ● Male ○ Female

Phone Number *(required)*: 9132813476
○ Home ● Mobile ○ Work

Language Preference *(optional)*: _____

Shipping Address: S.V. ROAD

City, State, Zip: 40092

Billing Address: _____
☐ *Same as Shipping* ✓

City, State, Zip: 02573

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: ROSS Policyholder DOB: 5/9/98 Relationship to patient: ● Self ○ Spouse ○ Other

Primary Insurance Carrier: TACKL Type: ○ Private ○ Medicare ● Medicare Advantage ○ Medicaid ○ Tricare

Claims Submission Address: USA, SHANTI NAGAR NO. 2

Subscriber ID/Policy Number: K10 Group Number: HIB Plan: 1C

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: 07/ 8/19

Fax completed form to 844-870-8875

For Lab Use Only

Sample Collected: 5/4/20 | Sample Received: 1/4/20