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: _____

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

Phone Number *(required)*: _____
○ Home ○ Mobile ○ Work

Language Preference *(optional)*: _____

Shipping Address: _____

_____

City, State, Zip: _____

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: __/__/____

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cologuard®

INFORMATION NEEDED

To Process a Cologuard® Order for Your Patient

Month DD, YYYY

Dear Cologuard Provider,

Exact Sciences Laboratories has recently received a Cologuard order for your patient; however, the below requested information is required before we can process the order.

Please complete the fields indicated below and fax the completed form to 1-844-870-8875.

Cologuard Order Number:	
Date Received by ES Labs:	6/09/2019
Health Organization Name:	123 Healthcare
Provider Name:	Rob Pizza, MD
Provider NPI:	1134225618
ICD-10 Codes Z12.11 and Z12.12: (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12]) *The above codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.*	Z12.11 Z12.12
Patient Name:	Allie <Last Name>
Patient Date of Birth:	6/9/1954
Patient Sex:	Female
Patient Phone Number:	608-555-1003
Patient Shipping Address:	*1440 Monroe St Madison WI 53711*
Please Confirm Secure Fax #: *For Results and Patient Information*	608-867-5309
Healthcare Provider Signature: *Please Sign this field if blank. We must have a valid Provider Signature to proceed.*	Yes
Insurance Type: *(Medicare, Medicare Advantage, Medicaid, Insurance, Self-Pay)*	*Medicare Advantage*
Insurance Carrier Name: *(Example: Blue Cross, Aetna) Please add the Claims address or fax a copy of the insurance card*	*Turner & Hooch*
Subscriber ID:	*8675309*
Group Number:	
Policy Owner/Holder Name:	*Allie <Last Name>*
Policy Owner/Holder Date of Birth:	

Thank you for your help!

Sincerely,
Exact Sciences Laboratories