GUARDANT

Guardant SHIELD™ | Test Requisition Form

NPI # 1184045619 | CLIA ID # 05D2070300 | CAP Accredited # 8765297

Fax completed form front & back pages to 888.483.2291

To place order online or access patient test status and results, please go to GuardantGo.com

All sections **MUST** be completed

1) PATIENT INFORMATION

First Name: Tom | Last Name: Cruise | DOB (mm/dd/yyyy): 9/8/1980 | Biological Sex: ○M ☑F | Medical Record #: 24057

Street Address: 1445 Seth Street | City: New Berlin | State: NB | Zip: 53146

Contact Phone # (Mobile preferred): (231)-542-3231 | Email: Tomcruise@gmail.com

Language preference (optional): ☑English ○Spanish Other: _____

2) PATIENT INSURANCE / BILLING INFORMATION

Please attach a copy of the front & back of the patient's insurance card and/or the patient face sheet

Patient Status at Blood Draw (Medicare only): ○Non-hospital Patient ☑Hospital Outpatient

○Insurance (Please fill in below) ☑Medicare ○Medicaid ○Self-pay (Please contact Client Services for billing information)

Insured First Name: Karan | Insured Last Name: Mathur | Insured DOB (mm/dd/yyyy): 05/11/1990

Relationship to Insured: ○Self ○Spouse ☑Child ○Other

Policy #: SPEG-105023 | Group #: UK-Company

Patient Authorizations and Assignment of Benefits Form is on the back of this form for the patient to review and sign.

3) PROVIDER INFORMATION

Account ID (Optional): GHSA-10572690 | Facility/Clinic Name: Unify Lab | NPI #: 1184045619

Provider First Name: Johny | Provider Last Name: Liver | Email: _____

Facility/Clinic Address: 1152 Elsie Drive | City: Texas | State: TX | Zip: _____ | Facility/Clinic Contact Phone #: 272-516-0570

4) ORDER INFORMATION AND STATEMENT OF MEDICAL NECESSITY

ICD-10 Code: ○Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

☑Other(s): _____

Blood Draw Location: ○In Office/Clinic ☑Patient needs assistance coordinating blood collection ○Quest Patient Service Center

Positive Test Result Disclosure:

○By checking this box, I request that Guardant Health provide the positive result to this patient.

Medical Professional Consent:

My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order Guardant Health, Inc. (GH) to perform Guardant SHIELD testing for this patient as indicated on this requisition, who is at average-risk for Colorectal Cancer (CRC) and eligible for guideline-recommended CRC screening. I attest that I have reviewed the medical consent on the back of this form with the patient. *(continued on back)*

Medical Professional Signature: Tom | **Order Date** (mm/dd/yyyy): 02/05/1982

5) SPECIMEN COLLECTION INFORMATION

Collection Date (mm/dd/yyyy): 11/22/1995 | Lab/Phlebotomy Company Name: Mehta Lab

Name of Person Collecting Specimen: Raman | Phlebotomy Contact Phone #: (242)-313-0908

Place BCK-ID label here

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24057
Patient Medical Record #

06 | 05 | 1998
DOB (mm/dd/yyyy)

3) Medical Professional Consent *(continued from front)*

As may be required by applicable state laws and regulations, I have informed the patient regarding Guardant SHIELD test, which is intended to be complementary to and not a replacement for current recommended colorectal cancer screening methods, and the patient has consented for the test ordered. I have obtained the patient's written consent to transmit the health data on this requisition form for the purpose of processing this order and performing Guardant SHIELD test.

I hereby authorize Guardant Health to release test results and relevant medical information to the patient's insurance carrier for reimbursement purposes. I have obtained the patient's consent for Guardant Health to submit and, if necessary, appeal claims on the patient's behalf, as well as for Guardant Health to receive payment directly from the patient's insurance carrier. I agree to provide a copy of relevant clinical history and medical records in order to support a request from a health plan, at no cost to Guardant Health. I acknowledge that patients who are United States residents may be enrolled in Guardant Access, Guardant Health's Financial Assistance Program if eligible and only upon signing the assignment of benefits form.

Patient Assignment of Benefits Form

ASSIGNMENT OF BENEFITS

I hereby assign and convey all applicable health insurance benefits and/or insurance reimbursement, as well as all rights and obligations that I have under my health plan, to Guardant Health for services performed by Guardant Health. I appoint Guardant Health as my authorized representative to:

- File medical claims with my health plan;
- File appeals and grievances with my health plan;
- File appeals or grievances with an external review committee at a state insurance board, independent review organization, Office of Personnel Management, Department of Labor or equivalent agency;
- File a complaint, regarding inaccurate claims processing, appeal processing or pricing to CMS or their agent regarding my Medicare Part C plan;
- Release medical and insurance information necessary to process claims or appeals;
- Obtain medical records related to services provided by Guardant Health when it is required to process a claim or appeal;
- Collect payment of any and all medical benefits and insurance proceeds directly from my health plan (including Medicare and Medicaid);
- Resolve any insurance-related matter regarding a service provided by Guardant Health directly with my health plan

I acknowledge and agree that I remain responsible for applicable co-payments, deductibles and co-insurance as required by my medical and/or other healthcare benefits plans. If I receive payment of medical and/or other health benefits on account of services provided by Guardant Health I shall pay Guardant Health the full amount of that payment.

AUTHORIZATION RELEASE

I hereby authorize Guardant Health to:

- Release any information necessary to my health benefit plan (or its administrator) regarding my medical conditions;
- Process and submit insurance claims generated in the course of examination or treatment; and
- Allow a photocopy of my signature to be used to process insurance claims, payment, grievances or appeals. This authorization will remain in effect until revoked by me in writing.

OUT-OF-NETWORK DISCLOSURE AND PATIENT CONSENT

I understand that Guardant Health services may be designated as an out-of-network service by some insurance plans. As a result, there may be costs associated with these services that are not covered by my insurance plan.I hereby consent for out-of-network services to be provided by Guardant Health.

You may visit www.guardanthealth.com/insurance for a list of insurance plans that consider Guardant Health services as in-network. Guardant Health will provide upon request, the estimated amount that Guardant Health expects to bill for services associated with out-of-network plans.

ERISA AUTHORIZATION

I hereby designate, authorize, and convey to Guardant Health, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, the following:

- The right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action against my health plan that I may have under such insurance policy and/or benefit plan; and
- The right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including, but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I understand I can revoke this authorization in writing at any time.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

I hereby consent Guardant Health to evaluate my eligibility for the Guardant Health Financial Assistance Program.

A photocopy of this Authorization shall be as effective and valid as the original.

Tom
PATIENT SIGNATURE

Tom Cruise
Print Patient Name

06 | 11 | 1981
Date (mm/dd/yyyy)

ScreeningSupport@guardanthealth.com | 855.722.7335

Guardant Health, Inc., 505 Penobscot Drive | Redwood City, CA 94063 | T 1.855.698.8887 | F 1.888.974.4258