MEDICAL NECESSITY FORM FOR BLOOD BASED BIOMARKER TESTING

SIGNED FORMS SHOULD BE KEPT IN THE PATIENT MEDICAL RECORD

PHYSICIAN NAME , MD

INSTITUTION

ADDRESS

CITY

STATE

ZIP

DATE MM/DD/YYYY

LABORATORY DIRECTOR NAME Dr. Funda Suer

LABORATORY NAME Durin Life Sciences, Northeastern University Life Sciences Testing Center

ADDRESS 147 South Bedford Street

CITY Burlington

STATE MA

ZIP 01803

RE: PATIENT FULL NAME

DOB *(MM/DD/YYYY)* MM/DD/YYYY

MEMBER ID

GROUP ID

MRN/PATIENT ID

Dear Medical Director,

I am writing this letter on behalf of my patient Patient Name to request coverage for the Duritect-AD™ test. This letter documents the medical necessity for this test to confirm the diagnosis of Alzheimer's Disease and provides information about the patient's medical history and treatment.

Patient History and Diagnosis:

Patient Name is a Age year old with a suspected diagnosis of Alzheimer's disease due to the following symptoms and clinical findings.

#1. Symptom #1 ICD Code:

#2. Symptom #2 ICD Code:

Family History

These symptoms, as well as the examination are indicative of Alzheimer's disease. The only way to confirm a diagnosis of Alzheimer's disease is to perform this test.

Molecular testing plays an important role in making a definitive diagnosis in cases of suspected Alzheimer's disease to treat the patient appropriately. An accurate diagnosis provides the following benefits to the patient:

- Benefit 1
- Benefit 2
- Benefit 3

I am requesting that Patient Name be approved for Duritect-AD™ test through Durin Life Sciences, Federal Tax ID #: 27-2247948 with the following CPT code(s): CPT Code . I am specifying Durin Life Sciences to perform Duritect-AD™ test analysis because Reason to use Duritect-AD™ for this testing.

I hope you will support this letter of medical necessity for Patient Name . Please feel free to contact me at Physician Phone if you have additional questions.

I, Physician Name hereby certify that the information provided in this Blood-Based Biomarker Test Order Form is complete and accurate to the best of my knowledge. I further certify that prior to me ordering the blood-based biomarker testing on the patient listed on this form, I have obtained the patient's (or their legally authorized representative's) signed, written consent form to order the blood-based biomarker testing, and that I have informed the patient (and/or their legally authorized representative) about the purpose of the biomarker test and the types of diseases the test is used for, what is required of the patient to perform the test, the reliability of positive or negative test results and the level of certainty that a positive test for the disease serves as a predictor of such disease, the importance of further testing, physician consultation, and counseling, and who will receive the blood-based biomarker test results.

Sincerely,

Physician Name , MD

NPI #: Physician NPI #