**PHYSICIAN CONSENT FORM FOR BLOOD BASED BIOMARKER TESTING**

**SIGNED FORMS SHOULD BE KEPT IN THE PATIENT MEDICAL RECORD**

DOCTOR\_NAME

DOCTOR\_COMPANY

DOCTOR\_ADDRESS

DOCTOR\_CITY, DOCTOR\_STATE

DOCTOR\_ZIP\_CODE

DATE\_NOW

Laboratory Director Name ……………………….

…………………………………………………………….

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Re: PATIENT\_NAME DOB: PATIENT\_DOB

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 TEST\_NAME. 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 PATIENT\_AGE year old PATIENT\_GENDER with a suspected diagnosis of   
……………………………………………… due to the following symptoms and clinical findings.

1. ………………………………………….. G30.0, G30.1, G30.8, G30.9

2. …………………………………………..

**Family History**

…………………………………………………………………………………………………………………………………………

These symptoms, as well as the examination are indicative of …………………………………………….

The only way to confirm a diagnosis of ……………………………………………… 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:

* …………………………………………………………………
* …………………………………………………………………
* …………………………………………………………………

I am requesting that PATIENT\_NAME be approved for TEST\_NAME testing through Durin Life Sciences, Federal Tax ID #: 27-2247948 with the following CPT code(s): ………………………………….... I am specifying Durin Life Sciences to perform TEST\_NAME analysis because ……………………………………………………………………………….. for this testing.

I hope you will support this letter of medical necessity for PATIENT\_NAME. Please feel free to contact me at PATIENT\_PHONE if you have additional questions.

I, ……………………………………………………………………… 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,

………………………………………………………………………… , MD

NPI #: ……………………………………………………………………….