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

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

<Physician Name>

<Institution>

<Address>

<City>, <State>

<ZIP>

<Date>

Laboratory Director Name [ Dr Funda SUER]

<Lab Name>

<Address 1>

<Address 2><City>, <ST>

<ZIP>

Re: <Patient Full Name> DOB: <MM/DD/YYYY>

Member ID: <Enter Member ID> Group ID: <Enter 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 <Age> year old <Gender > with a suspected diagnosis of   
<Disease Name> due to the following symptoms and clinical findings.

1. <Symptom #1 with ICD code>G30.0, G30.1, G30.8, G30.9

2. <Symptom #2 with ICD code>

**Family History**

<Family History>

These symptoms, as well as the examination are indicative of <Disease Name>.

The only way to confirm a diagnosis of <Disease Name> 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 <Test Name> testing through Durin Life Sciences, Federal Tax ID #: 27-2247948 with the following CPT code(s): <CPT Codes>. I am specifying Durin Life Sciences to perform <Test Name> analysis because <Reason to use Durin> 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#>