CancerIntercept™ Detect Indeterminate Resubmission (USA Domestic)

PATHWAY GENOMICS®

A CAP and CLIA Accredited Laboratory | 4755 Nexus Center Drive, San Diego, CA 92121 | 877.505.7374 | www.pathway.com | clientservices@pathway.com

CAP ACCREDITED™

LABORATORY USE ONLY:	DATE RECEIVED:	ACCESSION NO:	SPECIMEN ID:

PATIENT INFORMATION

First Name:_____ MI:_____

Last Name:_____

Gender: ☐ Male ☐ Female Height (in):_____ Weight (lb):_____

DOB (mm/dd/yy):_____ Age:_____

Primary Ethnicity: ☐ African ☐ Asian ☐ Caucasian ☐ Hispanic

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

Email:_____

Patient ID / MRN (optional):_____

Current Medications:_____

ORDERING PHYSICIAN (PRIMARY CARE PHYSICIAN REQUIRED)

First Name:_____ MI:_____

Last Name:_____ NPI #:_____

Medical Credentials: (MD, APRN, NP) _____

Facility Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Direct Office Contact (Required):_____

Phone:_____

PATIENT PAYMENT OPTIONS

☐ **OPTION 1: CREDIT CARD** (Pathway Genomics will contact you for additional information)

☐ **OPTION 2: INVOICE PRACTICE / INSTITUTIONAL BILL / FACILITY BILL**

☐ **OPTION 3: BILL INSURANCE** (attach front and back copy of insurance card)

Insurance Company Name:_____

Policy Number / Member ID:_____

I understand that if I have enrolled in an FSA/HSA or other medical spending account with my employer or my insurance carrier, that the provision on coordination of benefits in my coverage policy may result in an automatic deduction of out of pocket costs directly from that fund by the carrier or my employer. I understand that Pathway Genomics Corporation is in no way responsible or liable for that deduction, and will not reverse it, refund it or otherwise reimburse me for those amounts. I also understand that it is my responsibility to contact my insurance carrier or employer in advance of services regarding coordination of benefits issues that may impact such an account.

▶ Patient Initials:_____

Patient Acknowledgment and Authorization for Insurance Billing and Report Release: I acknowledge that I have provided accurate and true information to the best of my knowledge. **If I have provided my insurance information** for direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to Pathway Genomics (Pathway) and authorize Pathway to release medical information concerning my testing, including upon request my genetic testing results, to my insurer and any business associate of insurer (TPB, TPA, etc.). I authorize Pathway to be my Designated Representative for purposes of appealing any denial of health benefits. I understand that Pathway will not charge me for the difference between the amount billed to my insurer and the amount allowed by insurer; and that I am responsible for any amounts that my insurer determines are my responsibility after calculating deductibles, co-payments and co-insurance due under my policy. **I understand that I am legally responsible for sending Pathway Genomics Corporation any money received from my health insurance company for performance of this genetic test.**

▶ Patient Signature:_____ Date:_____

SPECIMEN INFORMATION (REQUIRED)

Date of Collection:_____

Time of Collection:_____

Collected and Registered By:_____

Specimen Type:

☐ Blood (2x10 ml Cell-free DNA BCT Streck Tubes) -ship at room temperature, do not refrigerate

☐ Blood (minimum 5 ml Frozen Plasma)- ship on dry ice

ADDITIONAL RESULTS RECIPIENT

Health Care Professional Name:_____

Phone:_____

Fax:_____

Email (for notification of results):_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

ICD-10 CODES REQUIRED

☑ Z12.9 - Special screening for unspecified malignant neoplasms

☐ Other:

_____

_____

_____

TEST REQUESTED – ICD-10 CODES REQUIRED

☑ **3104 - CancerIntercept™ Detect_Indeterminate_Resubmission**

ORDERING HEALTH CARE PROFESSIONAL - SIGNATURE REQUIRED

Informed Consent and Statement of Medical Necessity: I affirm that I am legally authorized to order laboratory tests OR that I am an authorized representative of a health care professional legally authorized to order laboratory tests; and hereby order the tests requested above, which includes any collection device necessary to obtain the samples for testing. I hereby confirm that the test(s) are medically necessary for the treatment and/or plan of care for the patient, and that the information supplied on the Pathway Genomics Clinical History Questionnaire is accurate to the best of my knowledge. I further hereby confirm that the information has been supplied about genetic testing and that an appropriate Pathway Genomics informed consent has been signed by the patient and is on file with a copy returned to Pathway Genomics.

Did patient opt-out for the use of their sample for research purposes in the consent?

☐ Yes ☐ No

▶ Signature:_____ Date:_____