exact sciences LABORATORIES

COLOGUARD® ORDER REQUISITION FORM

EXACT SCIENCES LABORATORIES, LLC
145 E. Badger Rd, Ste 100, Madison, WI 53713
P: 844.870.8879 | www.exactlabs.com
Fax completed form to 844.870.8875

REQUIRED – Provider Information

PROVIDER INFORMATION

Healthcare Organization: ____________________

Provider Name: ____________________

NPI #: ☐☐☐☐☐☐☐☐☐☐
(or DEA # if NPI is not available)

Location Address: ____________________

City, State, Zip: ____________________

Phone Number: ____________________

Fax Number*: ____________________
*To receive results for this order, please provide a **secure** FAX number

PATIENT INFORMATION

Patient ID/MRN: ____________________

First Name: ____________ **Last Name:** ____________

DOB (mm/dd/yyyy): ____________ **Sex:** ☐ Male ☐ Female

Optional: Patient label here or attach patient demographic sheet to order

We will need to reach your patient to verify order details. Phone number is required. Email follow-up is not always available depending on the information needed from the patient.

Initial Follow-up Type: ☐ Phone ☐ Email

Phone Number: ____________ ☐ Home ☐ Mobile ☐ Work

Email Address *(optional)*: ____________________

TEST INFORMATION

Test Name: Cologuard

Test Description: Stool-based DNA test with hemoglobin immunoassay component

Primary ICD-9 Code: (select one)
☐ V76.51: Special Screening for malignant neoplasm; intestine; colon
☐ Other: ____________

Secondary ICD-9 Code: (optional) ☐ ____________

The above ICD-9 code is listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.

Certification
By ordering Cologuard, I certify that I am a licensed medical professional authorized to order Cologuard. I acknowledge that the test is medically necessary and that the patient is eligible to use Cologuard. I accept responsibility for maintaining the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect a second sample from the patient if reportable results are not obtained from the initial sample.

____
Ordering Provider Signature **Date of Order**

REQUIRED – Patient Information

PATIENT ADDRESS

Shipping Address: ____________________
____
City, State, Zip: ____________________

Billing Address: ____________________
☐ Same as Shipping ____________________
City, State, Zip: ____________________

PATIENT INSURANCE/BILLING INFORMATION

Policyholder Name: ____________ **DOB:** ____________ **Relationship to patient:** ☐ Self ☐ Spouse ☐ Other

Please enclose copy of the front/back of insurance card, a patient demographic sheet, or complete the information below.

Type: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Tricare ☐ Self-Pay

Insurance Carrier/Program: ____________________

Subscriber ID/Policy Number: ____________ **Group Number:** ____________ **Plan:** ____________

PATIENT ASSIGNMENT OF BENEFITS NOTICE (AOB)

Authorization to assign benefits, accept financial responsibility, and disclose health records: *I authorize Exact Sciences Laboratories to bill my insurance/health plan and furnish them with my Cologuard order information, my test results, or other information requested for reimbursement, to appeal any reimbursement denial, and authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services.*

Patient Signature: ____________________ **Date:** ____________

For Laboratory Use Only
Sample Collected: ____________
Sample Received: ____________

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