EXACT SCIENCES

ONCOGUARD® LIVER TEST ORDER REQUISITION FORM

Test performed by Genomic Health, Inc.
an Exact Sciences Company
NPI: 1215003603 TIN: 77-0552594

Provider & Order Information

Recommended: Type all information. Editable, printable PDF available at OncoguardLiver.com/forms

PROVIDER INFORMATION

Healthcare Organization: _____

Provider Name: _____

NPI #: _____

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____
To receive faxed results for this order, please provide **secure** FAX number only

CLINICAL INFORMATION/TESTING INDICATION

ICD-10 Code(s):
See reverse side for a list of codes.

_____

Prior-Authorization Code: _____

Exact Sciences Study Code: _____
(if applicable)

_____
Ordering Provider Signature ***Date of Order***

SPECIMEN INFORMATION

Collection Date: _____ Collection Time: _____ ○ AM ○ PM
(mm/dd/yyyy)

Phlebotomist Name: _____ Phone Number: _____ Institution: _____

Oncoguard® Liver test specimen requirements *(tubes included in Blood Collection Kit):*
Peripheral Blood ▪ Three LBgard® Blood Tubes *(completely filled)* ▪ One Serum Separator Tube *(centrifuged)*

Patient Demographics

Patient ID/MRN: _____

First Name: _____

Last Name: _____

DOB: _____
(mm/dd/yyyy)

Sex: ○ Male ○ Female
(Biological sex/sex at birth is required)

Billing Address: _____

_____

Billing City: _____ State: _____ Zip: _____

Phone: _____
○ Home ○ Mobile ○ Work

Email: _____

Language Preference: _____

Patient Insurance/Billing Information

Attach a copy of the front & back of primary and/or secondary insurance cards.

Does patient wish Exact Sciences to bill their insurance? ○ Yes *(complete below)* ○ No *(patient will self-pay)*

Policyholder Name: _____ Policyholder DOB: _____ Relationship to patient: ○ Self ○ Spouse ○ Other

Primary Insurance Carrier: _____ Type: ○ Private ○ Medicare ○ Medicare Advantage ○ Medicaid ○ Tricare

Subscriber Name: _____ DOB: _____

Subscriber ID/Policy Number: _____ Group Number: _____ Plan: _____

Hospital Status at Time of Specimen Collection

(Medicare only)

○ Non-hospital Patient ○ Hospital Outpatient ○ Hospital Inpatient Discharge date: _____

Please fax completed form to 608-709-0769.

For Lab Use Only
Specimen Receipt Date: _____ Time: _____ ○ AM ○ PM

These diagnosis codes are provided as a reference only. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. We do not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff.

CONDITION	ICD-10 CODE
Cirrhosis	K70.30 — Alcoholic cirrhosis of liver without ascites K70.31 — Alcoholic cirrhosis of liver with ascites K74.5 — Biliary cirrhosis, unspecified K74.69 — Other cirrhosis of liver K74.60 — Unspecified cirrhosis of liver P78.81 — Congenital cirrhosis (of liver) K74.3 — Primary biliary cirrhosis K74.4 — Secondary biliary cirrhosis K71.7 — Toxic liver disease with fibrosis and cirrhosis of liver
Nonalcoholic steatohepatitis	K75.81 — Nonalcoholic steatohepatitis
Nonalcoholic fatty liver	K76.0 — Fatty (change of) liver, not elsewhere classified
Alcohol consumption	F10.10 — Alcohol abuse, uncomplicated F10.20 — Alcohol dependence, uncomplicated
Stage 4 primary biliary cholangitis	K74.3 — Primary biliary cirrhosis
Genetic hemochromatosis	E83.110 — Hereditary hemochromatosis
Alpha-1 antitrypsin deficiency	E88.01 — Alpha-1-antitrypsin deficiency
Hepatitis B	B16.1 — Acute hepatitis B with delta-agent without hepatic coma B16.9 — Acute hepatitis B w/o delta-agent and without hepatic coma B18.0 — Chronic viral hepatitis B with delta-agent B18.1 — Chronic viral hepatitis B without delta-agent B19.10 — Unspecified viral hepatitis B without hepatic coma
Hepatitis C	B17.10 — Acute hepatitis C without hepatic coma B18.2 — Chronic viral hepatitis C B19.20 — Unspecified viral hepatitis C without hepatic coma

Genomic Health, Inc.
301 Penobscot Dr. | Redwood City, CA 94063. | 1-844-870-8870

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