# COLOGUARD® ORDER REQUISITION FORM

**Stool-based DNA test with hemoglobin immunoassay component**

**EXACT SCIENCES LABORATORIES, LLC**
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NPI: 1629407069 TIN: 463095174

## Provider & Order Information

*Recommended: type all Provider information. Editable, printable PDF available at exactlabs.com*

### PROVIDER INFORMATION

Healthcare Organization Name: _____

Provider Name: _____

NPI #: | | | | | | | | | | |

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

*To receive results for this order, please provide **secure** FAX number only

### ORDER INFORMATION

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

**ICD-10 Code:**

◯ Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

◯ Other(s) _____

**Certification**

I am a licensed healthcare provider authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain 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 additional samples from the patient as appropriate.

_____

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

## Patient Demographics

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

Patient ID/MRN: _____

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): ___/___/_____ Sex: ◯ Male ◯ Female

Phone Number *(required)*: _____
◯ Home ◯ Mobile ◯ Work

Language Preference *(optional)*: _____

Shipping Address: _____

_____

City, State, Zip: _____

Billing Address: _____
☑ *Same as Shipping*

_____

City, State, Zip: _____

### PATIENT ETHNICITY AND RACE

*The completion of this section is optional.*

Is your patient of Hispanic or Latino origin or descent? ◯ Yes ◉ No

Please mark one or more to indicate your patient's race:

☐ White ☐ Black or African-American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native

## Patient Insurance/Billing Information

*Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching 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

Claims Submission Address: _____

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

Prior-Authorization Code *(if available)*: _____

### PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

*I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan and furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to Exact and authorize Exact to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I 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 or services determined by my plan to be provided by an out-of-network provider.*

Patient Signature: _____ Date: _____

**Fax completed form to 844-870-8875**

| For Lab Use Only | |
|---|---|
| Sample Collected: __/__/____ | Sample Received: __/__/____ |