

# Test Requisition Form

**PATHOLOGY: TIME SENSITIVE - URGENT RESPONSE REQUESTED**



Toll Free: (877) 886-6739 Fax: (858) 587-5874  
www.bioTheranostics.com

**SPECIMEN RETRIEVAL OPTION** I want bioTheranostics to request the specimen from Pathology (Please complete and fax this form to (858) 587-5874).

## ORDERING PHYSICIAN PATHOLOGY INFORMATION

Name			NPI			Name			NPI		
Email						Email					
Practice Name						Submitting Hospital/Laboratory Name					
Address						Address					
City		State		Zip		City		State		Zip	
Phone			Fax			Phone			Fax		
<small>Entering fax # certifies fax equipment is located in a secure area.</small>						<small>Entering fax # certifies fax equipment is located in a secure area.</small>					

## PATIENT INFORMATION SPECIMEN INFORMATION

Name			DOB			Block ID Number					
Social Security Number			Sex <input type="checkbox"/> M <input type="checkbox"/> F			Biopsy Site			Date Collected		
Address						Fixative Type (Recommended 10% Neutral-Buffered Formalin)					
City						Clinical Diagnosis					
Phone			Medical Record No.			ICD-9 Codes (Required) - List all codes that may apply.					

## BILLING INFORMATION Please attach front and back of patient insurance card(s) TESTS REQUESTED

Patient Status - Please check box for patient's hospital status when sample was sent. <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Non-Hospital Patient				<input type="checkbox"/> <b>CancerTYPE ID®</b> <i>Molecular Cancer Classifier</i>				<input type="checkbox"/> <b>breastcancerindex™</b> <i>Risk of 10-Year Distant Recurrence</i>			
Medicare Number _____ Date of Discharge _____				<input type="checkbox"/> <b>PRÉCIS Precision Medicine by bioTheranostics™</b>				<input type="checkbox"/> <b>CRC Biomarker Profile</b> <i>Predictive Testing for Colorectal Cancer</i> Includes: KRAS, BRAF, PIK3CA, & 10q23			
<b>BILL TO</b> <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare- Part B <input type="checkbox"/> Patient <input type="checkbox"/> Hospital/Facility				<input type="checkbox"/> <b>NSCLC Biomarker Profile</b> <i>Predictive Testing for Non-Small Cell Lung Cancer</i> Includes: EGFR, ALK, KRAS, c-MET, BRAF, PIK3CA, & 10q23				<b>INDIVIDUAL BIOMARKERS</b>			
<b>PHYSICIAN/PRACTITIONER CERTIFICATION</b> I hereby request and authorize bioTheranostics, Inc. to utilize the above information to process the tumor specimen for the indicated patient. I certify that the test is medically necessary and the results will be used in the management of the patient. I certify that I am authorized by law to request the test and I agree to provide the necessary information and records needed for billing.				Molecular <input type="checkbox"/> EGFR <input type="checkbox"/> KRAS <input type="checkbox"/> BRAF <input type="checkbox"/> PIK3CA				FISH <input type="checkbox"/> ALK <input type="checkbox"/> 10q23			
Signature _____ Date _____				IHC <input type="checkbox"/> c-MET							
Printed Name _____											

## ORDERING A TEST

1. Include completed Test Requisition, patient insurance documents and pathology report with specimen in shipping kit. Send kit via FedEx "Priority Overnight" to:  
**bioTheranostics, Inc.**  
9640 Towne Centre Drive, Suite 200  
San Diego, CA 92121

Complimentary FedEx "Priority Overnight" shipping is available by contacting Client Services at (877) 886-6739.

2. Test results will be faxed immediately upon test completion.

3. All blocks submitted will be returned following test completion. Please indicate block return address below (if different from pathology address listed above).

For questions, please contact bioTheranostics Client Services at (877) 886-6739.

## Block Return Address Information (if different from Pathology information above)

Name			Phone			Fax		
Address			City			State		Zip

Entering fax # certifies fax equipment is located in a secure area.