

# Test Requisition Form

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

## SPECIMEN RETRIEVAL OPTION

I want bioTheragnostics to request the specimen from Pathology (please complete and fax this form to (858) 587-5874)

I will arrange to have the specimen sent (fax this form to Pathology)

## 1. ONCOLOGIST INFORMATION

Name		NPI
Email		
Practice Name		
Address		
City	State	Zip
Phone (Physician Direct)	Fax	

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

## 2. PATIENT INFORMATION

Name		
Social Security Number		
DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Medical Record Number
Address		
City	State	Zip
Phone	Alternate Phone	

## 3. PATHOLOGIST INFORMATION

Name		NPI
Email		
Laboratory Name		
Sending Hospital/Facility		
Address		
City	State	Zip
Phone	Fax	

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## 4. SPECIMEN INFORMATION

Block ID Number	Biopsy Site
Date Collected	Date of Discharge (or Outpatient Encounter)
Fixative Type	

## 6. TESTS REQUESTED

- CancerTYPE ID**  
Test for cancer classification
- Breast Cancer Index**  
Test for risk of breast cancer recurrence (Combination H/I and MGI)
- KRAS**
- BRAF**
- KRAS and BRAF**

## 5. BILLING INFORMATION

ICD-9 Codes (Required) - List all codes that may apply.

Clinical Diagnosis:

Bill to:  Insurance  Medicare  HMO  Other  
Fill-in Medicare Information below Prior authorization may be required  
 Patient  Laboratory Account  Medicaid

**MEDICARE INFORMATION** - Please check box for patient's hospital status when sample was sent.

Hospital Inpatient  Hospital Outpatient  Non-Hospital Patient  
Medicare Number Date of Discharge Date of Specimen Collection

**PRIMARY INSURANCE INFORMATION** - Please attach a copy (front and back) of patient insurance card(s).  
Insurance Carrier Name

Policy Number/Member ID	Policy Holder Name	
Group Name	Group Number	
Address		
City	State	Zip
Phone	Fax	
Policy Holder DOB	Relation to Patient	
Policy Holder Phone	Alternate Phone	

**SECONDARY INSURANCE:** As a courtesy, secondary insurance information may be submitted. Please provide a copy (front and back) of the secondary insurance card in addition to the following information: secondary insurance carrier, policy number, group name and group number; billing address and phone number; policy holder name, ID#, date of birth, relation to patient and phone number.

## Block Return Address Information (if different from Section 3)

Name	Phone	Fax	
Address	City	State	Zip

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## 7. PHYSICIAN / PRACTITIONER CERTIFICATION

I hereby request and authorize bioTheragnostics, 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.

Signature	Date
Print Name	

**INCLUDE COMPLETED TEST REQUISITION FORM, PATIENT INSURANCE DOCUMENTS AND PATHOLOGY REPORT WITH SPECIMEN IN SHIPPING KIT. ALL BLOCKS SUBMITTED WILL BE RETURNED FOLLOWING TEST COMPLETION.**

**SEND SPECIMENS FEDEX "STANDARD OVERNIGHT" TO:**

**BIOOTHERANOSTICS, INC.**  
**11025 ROSELLE STREET, SUITE 200**  
**SAN DIEGO, CA 92121-1208**  
**TOLL FREE (877) 886-6739**