COLOGUARD® ORDER REQUISITION FORM

EXACT SCIENCES LABORATORIES, LLC
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P: 844E 870E 8879 | www.exactlabs.com
Fax completed form to 844.870.8875

Order Information

It is recommended to type the Provider Information on the editable PDF (available at exactlabs.com) and print copies for future orders.

PROVIDER INFORMATION

Healthcare Organization: Asprius Wausau Hospital

Provider Name: _____

NPI #: ☐☐☐☐☐☐☐☐☐☐

(or DEA # if NPI is not available)

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: (715) 847-0469

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

TEST INFORMATION

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

ICD-10 Code:

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

☐ Other(s)_____

The above 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**

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:** _____

Patient Information

This section can also be completed by attaching a patient demographic sheet and/or insurance card as long as all information is provided.

PATIENT INFORMATION

Patient ID/MRN: _____

First Name: _____ **Last Name:** _____

DOB* (mm/dd/yyyy): ___/___/____ **Sex:** ☐ Male ☐ Female
*Medicare/Med Advantage coverage for patients between ages 50-85

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

Email address *(optional)*:_____

Language Preference *(optional)*:_____

PATIENT ADDRESS

Shipping Address:_____
_____

City, State, Zip: _____

Billing Address: _____
☐ *Same as Shipping*
_____

City, State, Zip: _____

PATIENT INSURANCE/BILLING INFORMATION *(Attaching a copy of primary and/or secondary insurance cards is strongly recommended)*

Policyholder Name: _____ **Policyholder DOB:** ___/___/_____ **Relationship to patient:** ☐Self ☐Spouse ☐Other

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

Insurance Carrier/Program: _____

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

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For Laboratory Use Only
Sample Collected: __/__/____
Sample Received: __/__/____