DIACARTA

CAP ACCREDITED COLLEGE of AMERICAN PATHOLOGISTS

CLIA ID#: 05D2110800

Doc Number: Lab 109

OncoAssure™ Prostate Test Requisition Form

PART 1. PATIENT INFORMATION (REQUIRED)

Last Name | **First Name** | **Middle Initial** | **Date of Birth (MM/DD/YYYY)**

Street Address | **City** | **State** | **Zip Code**

Preferred Contact Phone # ☐ Home ☐ Mobile ☐ Work

Email

Gender ☐ Male ☐ Female ☐ Other

Race Identification

☐ African American ☐ White ☐ American Indian or Alaska Native ☐ Asian or Other Pacific Islander ☐ Hispanic or Latino ☐ Other/Unknown

PART 2. SAMPLE INFORMATION (REQUIRED)

☐ **FFPE** **Specimen ID** *A copy of the pathology report must be submitted with this document (Test Requisition Form)

Specimen Type: ☐ **Blocks** and/or ☐ **Slides** (indicate the number of slides sent_____) *Follow Sample Requirement and shipping instruction

FFPE block to be returned to: Attention **Address**

PART 3. CLINICAL INFORMATION (REQUIRED)

Age at Diagnosis

Most Recent PSA: _____ **ng/mL**

Biopsy Gleason Score Primary:_____ + Secondary:_____ (e.g. 3 + 4)

Percentage Positive Biopsy Core (%)

Date of Biopsy (MM/DD/YYYY)

Clinical Stage: Multiple Checkbox Selection

☐ cT1 ☐ cT2 ☐ cT3a ☐ cT3 (cT3b - cT4)

National Comprehensive Cancer Network® (NCCN®) Risk Category

☐ Very Low ☐ Low ☐ Favorable Intermediate ☐ Unfavorable Intermediate ☐ High ☐ Very High ☐ Not Available

PART 4. PRACTICE/CLINIC INFORMATION (REQUIRED)

Clinic Name or Account Number

Physician Name

Medical Professional Consent

My signature constitutes a Certification of Medical Necessity, I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I confirm that the patient has localized prostate cancer and an estimated life expectancy of ≥ 10 years. I certify that I will discuss with the patient their test results and how their results helped inform treatment recommendations. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein. I confirm that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers, such as DiaCarta, Inc. I authorize DiaCarta to release the information on this form, and other information provided by me, necessary to process a claim for this service.

Signature and Date

PART 5. ICD-10 CODES (MOST COMMONLY USED ICD-10 CODES) (REQUIRED)

☐ C61 Malignant neoplasm prostate ☐ D07.5 Carcinoma in situ of prostate ☐ R97.20 Elevated PSA

☐ Additional ICD-10 Code(s)

PART 6. PATIENT INSURANCE INFORMATION (REQUIRED)

Where applicable please include a photocopy of insurance card(s) (both sides)

Please Select a Billing Option & Complete the Information below ☐ Insurance ☐ Cash Pay ☐ Credit Card ☐ Check ☐ Client Bill

Primary Insurance Carrier | **Primary Insurance ID No.** | **Primary Insurance Group No.**

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Carrier | **Secondary Insurance ID No.** | **Secondary Insurance Group No.**

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other