DIACARTA

CAP ACCREDITED | CLIA ID#: 05D2110800
Doc Number: Lab 107

UriFind® Urothelial Carcinoma Test Requisition Form

PART 1. PATIENT INFORMATION (REQUIRED)

Last Name | First Name | Middle Initial | Date of Birth

Street Address | City | State | Zip Code

Preferred Contact Phone Number

☐ Home ☐ Mobile ☐ Work

Gender
☐ Male ☐ Female ☐ Other

ETHNICITY IDENTIFICATION
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race Identification
☐ African American ☐ Asian ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

PART 2. SAMPLE COLLECTION TYPE (REQUIRED)

☐ Urine

Collection Date & Time

I attest that the urine sample was properly collected in a sterile container, mixed with the Preservative provided and placed in refrigerator within 30 minutes of collection.

Signature and Date

Urine sample should be mixed with the Preservative provided and placed in refrigerator within 30 minutes after collection.

PART 3. PRACTICE/CLINIC INFORMATION (REQUIRED)

Practice/Clinic Name | Physician's NPI Number

Street Address | City | State | Zip Code

Email | Phone Number

Clinic Name or Account Number | Physician Name

Medical Professional Consent
My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order DiaCarta, Inc. to perform testing for this patient as indicated on this requisition, I have reviewed the medical consent on this form and will provide test interpretation to the patient as appropriate.

Signature and Date

PART 4. ICD-10 CODES (MOST COMMONLY U SED ICD-10 CODES) (REQUIRED)

☐ R31.0 Gross hematuria | ☐ R31.1 Microscopic hematuria | ☐ R31.2 Other Microscopic hematuria | ☐ R31.9 Hematuria, unspecifed

☐ Z12.6 Encounter for screening for malignant neoplasm of bladder | ☐ Additional ICD-10 code(s)

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PART 5. PATIENT INSURANCE INFORMATION (REQUIRED FOR INSURANCE COVERGE)

Where applicable please include a photocopy of insurance card(s) (both sides); for Credit Card please include a photocopy of a valid credit card (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

PART 6. PATIENT CONSENT

I _____ (Patient or legal guardian name), request and authorize the DiaCarta Clinical Laboratory to perform the requested test(s) for the person(s) listed above. I acknowledge the benefits, risks, and limitations outlined below. I understand that my specimen(s) will be submitted to DiaCarta for the purpose of lab testing. I authorize DiaCarta to store my specimen in case additional testing is necessary. The DiaCarta Clinical Laboratory does not return patient samples. I can request additional tests or send out samples to other institutions if there is enough sample. Once my test result has been released, remaining samples may be de-identified to be used for laboratory quality control or research. I can withdraw my consent at any time by calling the DiaCarta Laboratory at (800) 246-8878. My signature below indicates that I have read the above information. All my questions have been answered and my inquiries regarding the purpose of this test have been discussed and fully understood by me.

AFFIX SPECIMEN BARCODE HERE

Patient Name (Print)

Patient Signature

Date

THE END OF THE DOCUMENT