*Early*CDT®–Liver
Lesion Risk Assessment

Oncimmune® (USA) LLC
8960 Commerce Dr., Bldg. 6
De Soto, KS 66018
888-583-9030

Test Requisition Form

Note: This test is not intended for patients who are currently pregnant or have previously had cancer.

Provider and Order Information

Healthcare Organization: _____

Provider Name: _____

NPI #:										

Phone Number: _____

Location Address: _____

City, State, Zip: _____

Email Address:_____

Secure Fax #: _____
(Required to receive results via fax.)

ICD-10 Code(s):

□ K76.89 Other specified disease of liver (lesion)

□ Other_____ □ Other_____

The above codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for ordering the test, regardless of whether the code is listed above or not.

Certification

I am a licensed treating clinician authorized to order *Early***CDT-Liver.** This test is medically necessary, and the patient is eligible for *Early***CDT-Liver**. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Oncimmune (USA) LLC to obtain reimbursement for *Early***CDT-Liver.**

_____

Ordering Provider Signature **Date of Order**

Patient Information

First _____ MI_____ Last _____

DOB: _____ Age:_____ Sex: □ Male □ Female

Address_____City, State, Zip_____

Phone Number_____ SSN #:_____

Patient Authorizations, Assignment of Benefits (AOB) and Financial Responsibilities

I authorize Oncimmune (USA) LLC to bill my insurance/health plan and furnish them with my *Early***CDT-Liver** order information, test results, or other information requested for claim adjudication. I assign all rights and benefits under my insurance plan to Oncimmune and authorize Oncimmune to appeal and contest any claim denial, including in any administrative or civil proceeding necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for the services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider.

Patient Signature:_____ **Date**:_____

Patient Billing Information

PROVIDE FRONT AND BACK COPIES OF ALL INSURANCE CARDS

Primary insurance name_____ Secondary insurance name_____

Type: □ Insurance □ Medicare □ Medicare Advantage □ Medicaid □ Self Pay

Self Pay: Credit Card: □ Mastercard □ Visa Card #_____ Exp. Date_____ CVV_____

Specimen Collection Information

Collection Date:__/__/____ Collected By:_____Phone/Email:_____

Venipuncture: Draw blood into red-top serum tube or SST and send at ambient conditions. Minimum volume of 0.5 mL.
Capillary Collection: Collect blood in microtainer (fill to 400 line or above) and send at ambient conditions. Min. volume of 400 µL.
Specimens to be sent to 8960 Commerce Dr., Building #6, De Soto, KS 66018 V1 5.11.18

Oncimmune Lab Use Only:
Date Rec'd_____ Sample Type_____
Amt Rec'd_____ Rec'd by_____

Place patient identifier sticker in this box

oncimmune®

Questions? Call 1-888-583-9030

*Early*CDT®–Liver

Dear Patient,

At Oncimmune®, we are committed to the fight against cancer, and we would like to invite you to join us in the fight against liver cancer! With your help, together we can make an impact in how patients are diagnosed and treated for liver cancer.

So, what does it take? With your consent, Oncimmune will contact the provider for whom you provide contact details (the doctor treating your liver condition) and request copies of your health records, specifically information related to your liver health and diagnoses. Your information will be de-identified and combined with other participants' information to help advance the fight against liver cancer.

This is strictly voluntary, and your treatment is not conditioned on whether you choose to join us in this fight.

If you want to join us in the fight against liver cancer, please complete the form on the back and send to Oncimmune with your *Early***CDT-Liver** blood specimen, via fax (913-583-9001), email (ClientServices@oncimmune.com) or mail to the address at the bottom of this page.

Thank you for your help in advancing the diagnosis and treatment of liver cancer!

Sincerely,

oncimmune®

Oncimmune (USA) LLC

Oncimmune (USA) LLC
8960 Commerce Drive, Building #6, De Soto, KS 66018
Tel +1 913 583 9000 | Fax +1 913 583 9001
www.oncimmune.com

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.C. Parts 160 & 164)

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Phone: _____

Authorization:

I authorize the healthcare provider listed below to release/discuss (send) the protected health information pertaining to my identity, prognosis, diagnosis or treatment to Oncimmune USA LLC. This authorization includes all past, present and future periods and will expire on December 31, 2028.

Provider/Practice Name: _____ Phone: _____

Address: _____

Extent of authorization:

___I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

or

___I authorize the release of my complete health record with the exception of the following information:

- ___Mental health records
- ___Communicable diseases (including HIV and AIDS)
- ___Alcohol/drug abuse treatment
- ___Other (please specify):_____

I understand that:

- This medical information will be used by Oncimmune USA LLC for research purposes only; my identity will never be disclosed in any research project.
- I have a right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
- My treatment is not conditioned on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative *Date*

_____

Printed name of patient or personal representative *Relationship*