*Early*CDT®–Lung

Test Requisition Form

Oncimmune (USA) LLC
8960 Commerce Dr. Bldg 6
De Soto, KS 66018
913-583-9000

Provider and Order Information

Healthcare Organization: _____

Provider Name: _____

NPI #:										

Phone Number: _____

Location Address: _____

City, State, Zip: _____

Email Address:_____
(Required to receive results via web portal.)

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

ICD-10 Code(s) for Symptoms:

□ R91.1 Solitary Pulmonary Nodule
□ R91.8 Abnormal findings of Lung (Multiple Pulmonary Nodules)
□ J44.9 COPD
□ J48.9 Emphysema
□ J18.9 Chronic Pneumonia
□ J41.0 Chronic Bronchitis
□ R06.02 Shortness of Breath
□ R05 Persistent Cough
□ J98.4 Other disorders of lung
□ R07.9 Chest Pain
□ 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 medical professional authorized to order *Early***CDT-Lung**. This test is medically necessary and the patient is eligible for *Early***CDT-Lung** testing. 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-Lung** and to directly contact and collect a second sample from the patient as appropriate.

_____
Ordering Provider Signature **Date of Order**

Patient Information

First _____ MI_____

Last _____

DOB: _____ Age:_____

SSN #:_____ Sex: □ Male □ Female

Phone Number_____

Address_____

City, State, Zip_____

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

I authorize Oncimmune (USA) LLC to bill my insurance/health plan and furnish them with my EarlyCDT-Lung order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plan to Oncimmune and authorize Oncimmune to appeal and contest any reimbursement 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 my 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

PLEASE PROVIDE FRONT AND BACK COPIES OF ALL INSURANCE CARDS

Policyholder Name_____ Subscriber ID/Policy Number_____
Insurance Carrier/Program_____ Policyholder DOB___/___/_____
Relationship to patient □ Self □ Spouse □ Other Type: □ Insurance □ Medicare □ Medicare Advantage □ Medicaid □ Self Pay
Customer Service # from Insurance Card_____
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; transfer serum to pour-off tube 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. Whole blood is acceptable if sent in red top or SST tube when unable to centrifuge. Specimens to be sent to 8960 Commerce Dr. Bldg 6 De Soto, KS 66018

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