*Early*CDT®–Lung

Test Requisition Form

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

Provider and Order Information

Note: This test is not intended for patients who have a previous diagnosis of cancer (except basal cell carcinoma).

Healthcare Organization: _____

Clinician 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):

□ R91.1 Solitary Pulmonary Nodule □ R91.8 Abnormal findings of Lung (Multiple Pulmonary Nodules)

□ Other_____

The above codes are listed as a convenience. Ordering clinicians 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-Lung**. This test is medically necessary and the patient is eligible for *Early***CDT-Lung**. 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.**

_____

Ordering Clinician 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 EarlyCDT-Lung 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

PLEASE PROVIDE FRONT AND BACK COPIES OF ALL INSURANCE CARDS

Primary insurance_____ Secondary insurance _____

Relationship to patient □ Self □ Spouse □ Other 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, send at ambient conditions. Minimum volume of 0.5 mL.serum or 1.0 mL of whole blood.
Capillary Collection: Collect blood in microtainer (fill to 400 line or above) and send at ambient conditions. Min. volume of 400 µL.
Send specimen to 8960 Commerce Dr., Bldg. 6, De Soto, KS 66018 V1 5.21.18

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