



Note: This test is not intended for patients who are currently pregnant or have previously had cancer (except basal cell carcinoma).

### Provider and order information

Healthcare organization	<b>ICD-10 code(s)</b> <input type="checkbox"/> K76.89 Other specified disease of liver (lesion) <b>required for third-party billing</b> <input type="checkbox"/> B18.0 Chronic Viral Hepatitis B w/ delta-agent <input type="checkbox"/> K74.0 Hepatic Fibrosis <input type="checkbox"/> B18.1 Chronic Viral Hepatitis B w/o delta-agent <input type="checkbox"/> K73.9 Chronic Hepatitis, unspecified w/o delta-agent <input type="checkbox"/> K70.31 Alcoholic Cirrhosis of liver w/ ascites <input type="checkbox"/> K75.4 Autoimmune Hepatitis <input type="checkbox"/> K70.30 Alcoholic Cirrhosis of liver w/o ascites <input type="checkbox"/> B18.2 Chronic Viral Hepatitis C <input type="checkbox"/> E83.119 Hemochromatosis, unspecified <input type="checkbox"/> Other _____
Clinician name	
Clinician NPI #	
Phone number	
Location address	
City, State, Zip	
Email address	
Secure fax #	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.
<b>Certification</b> I am a licensed treating clinician authorized to order <i>EarlyCDT—Liver</i> . This test is medically necessary, and the patient is eligible for <i>EarlyCDT—Liver</i> . I will maintain the privacy of test results and related information as required by HIPAA. I authorize Oncimmune <sup>®</sup> (USA) LLC to obtain reimbursement for <i>EarlyCDT—Liver</i> .	
_____ Ordering provider signature <span style="float: right;">Date of order</span>	

### Patient information

First	MI	Last
Date of birth	Age	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City, State, Zip, Country	
Phone number	Social Security number (last 4 digits)	

### 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—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: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Self Pay	Prior Authorization _____
<input type="checkbox"/> Mastercard <input type="checkbox"/> Visa Card # _____	Expiration Date _____ CVV _____
Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	

### Specimen collection information

Collection date: / / Collected by: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Venipuncture:** Draw blood into red-top serum tube or SST, send at ambient conditions. Min. volume of 0.5 mL serum or 1.0 mL whole blood.

**Capillary collection:** Collect blood in Microtainer<sup>®</sup> (fill to 400 line or above), send at ambient conditions. Min. volume of 400 µL.

Specimens to be sent to Oncimmune<sup>®</sup> (USA) LLC, 8960 Commerce Dr., Building #6, De Soto, KS 66018.

<b>Oncimmune lab use only</b> Date received: / /      Sample type: _____ Amount received: _____      Received by: _____	Place patient identifier sticker in this box
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## Finger Stick blood collection instructions

Collection kit supplied by Oncimmune<sup>®</sup>



Complete and sign  
**EarlyCDT—Liver** test requisition

Patient should wash  
and warm hands



Identify puncture site (red).  
Clean thoroughly with alcohol  
wipe & air dry

Twist off tab  
on lancet



Press firmly against  
puncture site until  
click is heard

Return with sample for proper disposal

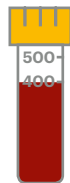
Wipe away first drop of blood.  
Remove yellow cap of Microtainer<sup>®</sup> tube



Touch collector end  
of tube to drop of blood,  
apply intermittent pressure  
along finger\*

Note: some may need more than 1 finger stick

Fill tube to the 400 mark or above.  
Replace cap and label tube  
with barcode sticker



### Prepare for shipment:

- Place sample in bubble wrap provided.
- Place sample and lancets in biohazard bag.
- Place bag and requisition in collection kit box.
- Place box in FedEx<sup>®</sup> Clinical Pak with prepaid waybill affixed.

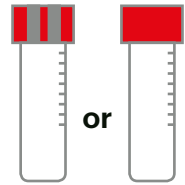
## Traditional blood draw instructions

Collection kit supplied by Oncimmune<sup>®</sup>



Complete and sign  
**EarlyCDT—Liver** test requisition

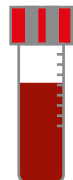
Blood specimen drawn into a  
red-top serum tube or serum-  
separator tube (SST)



If SST, centrifuge specimen per  
manufacturer's recommended procedures.  
If sending red-top serum tube, send  
specimen without processing

Label tube with 2 unique patient  
identifiers and/or barcode label

Note: minimum of 0.5 mL of serum  
or 1.0 mL of whole blood



Keep refrigerated  
(not frozen) until ready to  
ship, unless shipped same day



### Prepare for shipment:

- Place sample in bubble wrap provided.
- Place sample in biohazard bag.
- Place bag and requisition in collection kit box.
- Place box in FedEx<sup>®</sup> Clinical Pak with prepaid waybill affixed.

\*Do not scrape skin surface to collect blood; blood will freely flow to bottom of tube.