



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	ICD-10 code(s) <input type="checkbox"/> K76.89 Other specified disease of liver (lesion) required for third-party billing <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	
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.
Certification 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 [®] (USA) LLC to obtain reimbursement for <i>EarlyCDT—Liver</i> .	
_____ Ordering provider signature Date of order	

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"/> Medicare Advantage <input type="checkbox"/> Medicaid <input type="checkbox"/> Self Pay	
<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[®] (fill to 400 line or above), send at ambient conditions. Min. volume of 400 µL. Specimens to be sent to Oncimmune[®] (USA) LLC, 8960 Commerce Dr., Building #6, De Soto, KS 66018.

Oncimmune lab use only Date received: / / Sample type: _____ Amount received: _____ Received by: _____	Place patient identifier sticker in this box
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