*Early*CDT®—Lung

Nodule Risk Assessment
Test Requisition Form

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

Provider and order information

Healthcare organization

Clinician name

NPI
#

Phone number

Location address

City, State, Zip

Email address

Secure fax #

ICD-10 code(s) – pulmonary nodule required for third-party billing (R91.1 or R91.8)

☐ 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 provider signature _____ Date of order _____

Patient information

First _____ MI _____ Last _____

Date of birth _____ Age _____ Sex: ☐ Male ☐ 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 *Early*CDT—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 – PROVIDE FRONT AND BACK COPIES OF ALL INSURANCE CARDS

Primary insurance name _____ Secondary insurance name _____

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

☐ Mastercard ☐ Visa Card # _____ Expiration Date _____ CVV _____

Relationship to patient: ☐ Self ☐ Spouse ☐ 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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