esopredict™

Test Requisition Form

Accession #

A Patient Information

Last Name	First Name	MI
Patient Medical Record #	Patient DOB	Patient Gender ☐ M ☐ F
Address		Apt. #
City	State / Zip Code	Country
Patient Phone (Primary)	Patient SSN	

B Ordering Physician Information

Office / Practice / Institution Name			
Ordering Physician		NPI #	
Office Contact	Address		
City	State	Zip Code	Country
Office Phone (Primary)		Fax	

C Billing & Insurance Information

☐ **Attach a copy of patient insurance card (front & back) or face sheet**

Method of Payment
☐ Bill Private Insurance ☐ Bill Medicare ☐ Patient Self-Pay ☐ Client Bill

Primary Insurance			Name on Credit Card
Policy #	Group #	Insured Name	Cardholder Address
Insured Phone (Primary)	Insured DOB	Credit/HSA/FSA Card #	Expiration Date (MM/YY)

For Traditional Medicare Patients Only

At the time of collection, was this patient: ☐ Non-hospital ☐ Hospital Outpatient ☐ Hospital Inpatient; date of discharge: ____________________

If specimen stored for > 30 days from date of collection, provide the date specimen is pulled from archive: ____

D Pathology Information

Hospital / Institution Name	
Submitting Pathologist Name	Phone
Email	Fax

E Comments, Remarks or Special Requests

F Specimen Information

Specimen Site	Specimen ID	Collection Date	Histology / Diagnosis

☐ If specified here, Previse will contact the pathology department to request patient's specimen

☐ Pathology report included

G ICD-10 Code(s) listed

☐ K22.70 — Barrett's esophagus Non-Dysplastic
☐ K22.710 — Low Grade Dysplasia
☐ K22.719 — Indefinite for Dysplasia
☐ Other:

X For Internal Use Only

Date (MM/DD/YYYY):	Initials:

Additional Order Information

Treating provider name *(if different than section B):*

Practice Name	Phone/Fax	
Address ☐ same as requestor		
City	State	Zip Code

Physician Signature

Test requested: Esopredict™-Barrett's esophagus

I hereby certify that the request for Esopredict™ – Barrett's Esophagus for which reimbursement from Medicare or third party payors will be sought by Previse is reasonable and medically necessary for the diagnosis, care and treatment of this patient's condition.

Ordering Physician Signature	Date (MM/DD/YYYY)

Please fax or email completed form along with copy of pathology report and endoscopy report (if available) to **833-356-5946** or **orders@previsedx.com**

Instructions for Completing the Test Requisition Form

Please complete information for all sections to ensure prompt sample processing.

1. **Section A** includes information about the patient.

2. **Section B** includes information about the ordering healthcare provider.

3. **Section C** includes information about the patient's insurance such as insurer name, Policy ID, Group Number, insured person's billing preference, and credit card/HSA/FSA card information for payment processing. **PLEASE INCLUDE A COPY OF THE PATIENT'S CURRENT INSURANCE CARD (FRONT & BACK) or PATIENT FACE SHEET** with the test order form. If the person completing the test requisition form cannot provide the patient billing information required in Section C, please provide a name and contact information for a responsible person who can share the information with our lab:

   Name ______________________ Title ______________________ Department ______________________

   Phone Number ____________________________ Fax Number ________________________________

4. **Section C** also includes important information that needs to be filled out for Traditional Medicare patients (Fee-For-Service Medicare beneficiaries only-not those with benefits under a Medicare Advantage health plan).

5. **Section D** includes information about the hospital or facility that will provide the tissue sample for analysis.

6. **Section E** is a space to include free text information.

7. **Section F** includes more information about the location and identification of the requested tissue sample and whether Previse lab should be instructed to contact the facility directly to obtain the sample for processing.

8. **Section G** includes relevant ICD 10 diagnosis codes related to the patient's tissue sample.

9. Complete the Additional Order Information section if the treating provider is different from the ordering provider. If the ordering provider is the same as the treating provider, please check "same as requestor" box.

10. Physician Signature section: The ordering healthcare provider must sign and date the test requisition form prior to sending it to the Previse lab. Only a licensed MD, DO, Physician Assistant, or Nurse Practitioner may sign the form.

11. Please fax or email completed form along with copy of pathology report and endoscopy report (if available) to **833-356-5946** or **orders@previsedx.com**.

Previse Lab will provide an order confirmation within 24 hours of receipt (unless otherwise requested or noted) of completed Test Requisition Form and available copies of the patient's pathology and endoscopy reports.

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