COLOGUARD® ORDER REQUISITION FORM

EXACT SCIENCES LABORATORIES, LLC
145 E. Badger Rd, Ste 100, Madison, WI 53713
P: 844-870-8879 | www.exactlabs.com
Fax completed form to 844-870-8875

Provider & Order Information

Recommended: type all Provider information.
Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization: _____

Provider Name: _____

NPI #: | | | | | | | | | | |

(or DEA # if NPI is not available)

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

*To receive results for this order, please provide **secure** FAX number only

TEST INFORMATION

Test Name: Cologuard

Test Description: Stool-based DNA test with hemoglobin immunoassay component

ICD-10 Code:

☐ Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

☐ Other(s) _____

We will not ship a collection kit to the patient if ICD-10 coding is missing. The above code is listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.

Certification

I am a licensed medical professional authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect a second sample from the patient as appropriate.

_____

Ordering Provider Signature **Date of Order**

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan & furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights & benefits under my insurance plans to Exact & authorize Exact to appeal & contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for 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 Information

Attach a copy of the front & back of primary and/or secondary insurance cards.

PATIENT INFORMATION: *Recommended – also attach a patient demographic sheet*

Patient ID/MRN: _____

First Name: _____ Last Name: _____

DOB* (mm/dd/yyyy): ___/___/_____ Sex: ☐ Male ☐ Female

*Medicare/Med Advantage coverage for patients between ages 50-85

Phone Number *(required)*: _____

☐ Home ☐ Mobile ☐ Work

Email address: _____

Language Preference *(optional)*: _____

PATIENT ADDRESS

Shipping Address: _____

_____

City, State, Zip: _____

Billing Address: _____

☐ *Same as Shipping*

_____

City, State, Zip: _____

Patient Insurance/Billing Information

Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Policyholder Name: _____ **Policyholder DOB:** ___/___/_____ **Relationship to patient:** ☐ Self ☐ Spouse ☐ Other

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

Insurance Carrier/Program: _____ **Customer Service # on Insurance Card:** _____

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ **Group Number:** _____ **Plan:** _____

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For Laboratory Use Only
Sample Collected: __/__/_____
Sample Received: __/__/_____