genomic health | oncotype DX Breast Cancer Assay

Reset Form

PATHOLOGY PRE-ORDER FORM

Attach or Write Requisition Barcode

For Pathology:

R _ _ _ _ _ _ _

Please order Oncotype DX™ for _____

PATIENT NAME (FIRST) PATIENT NAME (LAST)

FAX TO PATHOLOGY _____

PLEASE DO NOT SEND THIS FORM DIRECTLY TO GENOMIC HEALTH. THIS FORM MUST BE ACCOMPANIED BY AN ONCOTYPE DX REQUISITION FORM AND MUST CONTAIN THE REQUISITION BARCODE NUMBER.

Instructions for Pathology: On the Oncotype DX Requisition Form, please complete the patient name and date of birth as well as all other fields not on this form (including Pathology Information). Place a barcode label from the requisition form or write the barcode number in the top right corner of this form. Submit both the Requisition Form and this form with the Oncotype DX specimen.

I. ACCOUNT INFORMATION

ACCOUNT NAME

ADDRESS

ADDRESS

CITY STATE ZIP

PHONE #

II. PATIENT INFORMATION

NAME OF PATIENT: Last name First name MI

DOB Sex: ☐ Female ☐ Male

ADDRESS

CITY STATE ZIP

PHONE #

MEDICAL RECORD/PATIENT # SSN

III. BILLING INFORMATION

SUBMITTING DIAGNOSIS

ICD-9 CODE

METHOD OF PAYMENT

☐ BILL PRIVATE INSURANCE
☐ BILL MEDICARE
☐ BILL MEDICAID

☐ BILL ACCOUNT ***No further billing information required.***

☐ PATIENT SELF-PAY: ***Check (US only), certified funds, money order, or credit card information required for processing. No further billing information required.***

Name on Credit Card

CC#

Expiration Date ____/____

MEDICARE ONLY:

☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital Patient (> 24 Hours)

☐ SIGNED ABN ATTACHED IF REQUIRED

☐ COPY OF FRONT AND BACK OF PATIENT INSURANCE CARD ATTACHED ***If not, fill out all information below and to right.***

MEMBER ID # GROUP #

RELATIONSHIP TO INSURED:

☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

NAME OF INSURED: Last name First name MI

DOB Sex: ☐ Female ☐ Male

PRIMARY INSURANCE NAME

PRIMARY INSURANCE ADDRESS

CITY

STATE ZIP

PRIMARY INSURANCE PHONE #

REFERRAL/AUTHORIZATION #

SECONDARY INSURANCE: ☐ YES ☐ NO

If you would like us to bill secondary insurance, you must attach a copy of the front and back of the secondary insurance card.

IV. REQUIRED SIGNATURE

SIGNATURE OF ORDERING PHYSICIAN

X _____

DATE

PRINT NAME

To be medically necessary, diagnostic laboratory tests must be ordered by a treating physician (or their authorized representative) who provides a consultation or treats a patient for a specific medical problem and who uses the findings in the management of the patient. If the ordering physician is not the treating physician, the ordering physician confirms by signing this form that the treating physician has ordered the Oncotype DX™ Breast Cancer Assay. This order may have been conditioned on findings from the initial pathological examination.

V. ORDER INFORMATION

TREATING PHYSICIAN **UPIN**

PHONE # FAX #

SPECIALTY: ☐ Surgery ☐ Oncology ☐ Other _____

OVERNIGHT MAIL ADDRESS: ☐ Same as account

CITY STATE ZIP

REPORT DELIVERY PREFERENCES:

☐ Overnight Mail ☐ Fax ☐ Online Secure Access

E-MAIL ADDRESS (for report notification)

ADDITIONAL PHYSICIAN (optional) **UPIN**

PHONE # FAX #

SPECIALTY: ☐ Surgery ☐ Oncology ☐ Other _____

OVERNIGHT MAIL ADDRESS: ☐ Same as account

CITY STATE ZIP

REPORT DELIVERY PREFERENCES:

☐ Overnight Mail ☐ Fax ☐ Online Secure Access

E-MAIL ADDRESS (for report notification)

Comments:

301 Penobscot Drive Redwood City, CA 94063 (866) ONCOTYPE (662-6897) www.oncotypeDX.com