NEO GENOMICS

NeoLAB® Solid Tumor Liquid Biopsy Requisition

Phone 866.776.5907 / Fax 239.690.4237
neogenomics.com

Client Information

Required Information

Account #: ____________ **Account Name:** ____________

Street Address: ____________

____

City, ST, ZIP: ____________

Phone: ____________ **Fax:** ____________

Requisition Completed by: ____________ Date: ________

Ordering Physician (please print: Last, First): ____________ NPI #: ________

Treating Physician (please print: Last, First): ____________ NPI #: ________

The undersigned certifies that he/she is licensed to order the test(s) listed below and that such test(s) are medically necessary for the care/treatment of this patient.

Authorized Signature: ____________ Date: ________

Billing Information

Required: Please include face sheet and front/back of patient's insurance card.

Patient Status (Must Choose 1):

- ☐ Non-Hospital Patient
- ☐ Hospital Patient (in)
- ☐ Hospital Patient (out)

Bill to: ☐ Client Bill ☐ Insurance

☐ Medicare ☐ Medicaid ☐ Patient/Self-Pay

☐ Split Billing—Client (TC) and Insurance (PC)

☐ OP Molecular to MCR, all other testing to Client

☐ Bill charges to other Hospital/Facility:

____

Prior Authorization # ____________

See the NeoGenomics.com Billing section for more info.

Clinical Information

Required: Please attach patient's pathology report (required), clinical history, and other applicable report(s).

ICD 10 (Diagnosis) Code/Narrative (Required): ____________

Reason for Referral: ____________

☐ New Diagnosis ☐ Relapse ☐ In Remission ☐ Monitoring

Staging: ☐ 0 ☐ I ☐ II ☐ III ☐ IV Note: ____________

Patient Information

Last Name: ____________ ☐ **Male** ☐ **Female**

First Name: ____________ **M.I.** ________

Other Pt ID/Acct #: ____________

Date of Birth: mm______ / dd______ / yyyy______

Medical Record #: ____________

Client represents it has obtained informed consent from patient to perform the services described herein.

Blood Specimen Information

Specimen ID: ____________

Hospital Discharge Date: mm______ / dd______ / yyyy______

Collection Date: mm______ / dd______ / yyyy______

Collection Time: ____________ ☐ AM ☐ PM

☐ Peripheral Blood: Streck Cell-Free DNA BCT® # ____________

Mobile Phlebotomy Request

PLEASE FAX

Patient Phone: ____________ mobile preferred

Patient Email (optional): ____________

Patient Home Address: ____________

Apartment, Suite, etc. (optional): ____________

City: ____________

ST: ____________ **ZIP:** ____________

☐ NeoGenomics InVisionFirst®-Lung Liquid Biopsy collection and shipping kit was provided to the patient.

Order Liquid Biopsy below and **please fax** this completed requisition, pathology report, and face sheet or insurance information to 239.690.4237.

Client represents it has obtained patient's consent to be contacted by third-party service.

Test Selection

☐ **NeoLAB® Solid Tumor Biopsy**

Specimen Requirements

Collect into Streck Cell-Free DNA BCT® tubes provided only. Do not refrigerate. Special collection and shipping requirements apply. Please see instructions provided in NeoLAB® Solid Tumor Liquid Biopsy Kit or contact Client Services at 866.776.5907 option 1. Please order any other testing and return it to NeoGenomics using the appropriate separate requisitions and transport kits.

Additional Billing Information

Any organization referring specimens for testing services pursuant to this Requisition Form ("Client") expressly agrees to the following terms and conditions.

1. **Binding Service Order.** This Requisition Form is a legally binding order for the services ordered hereunder ("Services") and Client agrees that it is financially responsible for all tests billable to Client hereunder.

2. **Third Party Billing by NeoGenomics and Right to Bill Client.** Client agrees to accurately indicate on the front of the Requisition Form that either Client should be billed (e.g., Client receives reimbursement pursuant to a non-fee-for-service basis, including, but not limited to, a capitated, diagnostic related group ("DRG"), per diem, all-inclusive, or other such bundled or consolidated billing arrangement) or NeoGenomics should bill the applicable federal, state or commercial health insurer or other third party payer (collectively, "Payers") for all Services ordered pursuant to this Requisition Form. For all such Services billable to Payers, Client agrees to provide all billing information necessary for NeoGenomics to bill such payer. In the event NeoGenomics: (i) does not receive the billing information required for it to bill any Payers within ten days of the date that any Services are reported by NeoGenomics; (ii) the Services were performed for patients who have no Payer coverage arrangements; or (iii) the Payer identified by Client denies financial responsibility for the Services and indicates that Client is financially responsible, NeoGenomics shall have the right to bill such Services to Client.

Test Descriptions

Please see complete test descriptions and all available tests at our website, www.neogenomics.com.

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