Asuragen®

Attn: CLIA Laboratory
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miRInform™ Pancreas Panel Requisition Form

1 | SUBMITTING PHYSICIAN ACCOUNT INFORMATION

Physician/NPI #:_____

Street Address: _____

City, State, ZIP: _____

Country:_____

Phone #:_____

Email Address:_____

Fax #: _____

Additional Physician/NPI #: _____

Account #:_____

Results delivery: ☐ fax ☐ mail

or

2 | SUBMITTING LABORATORY ACCOUNT INFORMATION

Laboratory Name:_____

Street Address: _____

City, State, ZIP: _____

Country:_____

Phone #:_____

Email Address:_____

Fax #: _____

Physician/NPI #:_____

Account #:_____

Results delivery: ☐ fax ☐ mail

3 | PATIENT INFORMATION

☐ Patient's Face Sheet attached to the Test Requisition

Name: _____
Last First Middle Initial

DOB: _____ Sex: ☐ MALE ☐ FEMALE
(DD/MM/YYYY)

Street Address: _____

City, State, ZIP: _____

Phone #: _____ MR # or SSN: _____

4 | TEST MENU

1. ☐ **Pancreatic adenocarcinoma test - microRNA (miRNA) on FFPE Tissue**

5 | SPECIMEN INFORMATION - MATERIALS SHIPPED

Date of surgery (sample collection):_____

Date sent to Asuragen CLIA Laboratory: _____

Specimen block ID: _____

Specimen accession number:_____

☐ Histology slides: 1 H&E slide and 8 unstained, de-paraffinized slides needed

unstained, de-parrafinized slides:_____ # H&E slides: _____

☐ FFPE block # FFPE specimens: _____ ☐ FFPE block to be returned to the submitter (additional $10 charge)

☐ Shipment notification sent to Asuragen
(see Specimen Shipping and Handling Requirements)

6 | BILLING INFORMATION

As a courtesy we will bill your insurance. We do not accept Medicaid. Please attach a copy (front and back) of insurance card (s); complete billing information must be provided below.

NOTE: If patient is a minor, parent or guardian information is required.

☐ **Patient's Face Sheet attached to the Test Requisition**

Insurance carrier: _____

Policy #: _____

Group name: _____

Group #:_____

Street Address: _____

City, State, ZIP:_____Country: _____

Phone #:_____Fax #: _____

Policy holder phone #: _____

Policy holder DOB: _____
(DD/MM/YYYY)

Relation to patient: _____

Bill to: ☐ Insurance ☐ Patient ☐ Medicare ☐ Laboratory Account

SECONDARY INSURANCE: As a courtesy you may also submit secondary insurance information. Please attach a copy (front and back) of your secondary insurance. You must also provide the following information: secondary insurance carrier, policy #, group name and group #, billing address and phone #, policy holder name, ID #, DOB, relation to patient and phone #.

7 | DIAGNOSIS (REQUIRED INFORMATION)

Clinical diagnosis:_____

ICD9 Codes: _____ _____ _____

Pertinent patient clinical history: _____

_____

_____

8 | ORDERING PHYSICIAN'S SIGNATURE

I hereby certify that the request for the Pancreatic adenocarcinoma miRNA qRT-PCR testing from which reimbursement from Medicare, or third party payors, will be sought by Asuragen, is reasonable and medically necessary for the diagnosis, care and treatment of this patient's condition. I also authorize Asuragen to send on my behalf this patient's test results to the patient's third party payor in connection with an appeal of a reimbursment denial or other reimbursement matter, but only where Asuragen has previously attempted to obtain the reimbursement without the release of such results. Additionally, I certify that this patient has been notified that additional testing via Asuragen's CLIA Laboratory process has been requested.

Signature	Print name	Order date

9 | LABORATORY USE ONLY

Specimen Received:	DATE: _____	TIME:_____	Box opened by:_____
Primary Data Entry:	DATE: _____	TIME:_____	Initials: _____
Data Entry Verified by:	DATE: _____	TIME:_____	Initials: _____