



# TEST REQUEST FORM

Attach Patient ID Label Here

**INSTRUCTIONS** - Please complete this form in block capital letters, using blue or black ink.

## 1. CALL VERISTRAT SUPPORT HOTLINE PRIOR TO SPECIMEN COLLECTION: 1-866-432-5930

## 2. ORDERING PHYSICIAN INFORMATION

ORDERING PHYSICIAN:	NPI (PREFERRED)/UPIN:	CLIENT/PRACTICE NAME:
ADDRESS:	CITY:	STATE:
ZIP:	<b>FAX NO: (For test result notification)</b>	PRIMARY CONTACT PHONE NO.:
PRIMARY CONTACT NAME:		

## 3. PATIENT INFORMATION

NAME OF PATIENT: LAST	FIRST	MI
DOB: MM/DD/YYYY	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE: HOME	WORK	MOBILE
MEDICAL RECORD/PATIENT #:		

## 4. SPECIMEN INFORMATION

DATE OF COLLECTION: MM/DD/YYYY
SAMPLE TYPE: <input type="checkbox"/> INITIAL <input type="checkbox"/> REDRAW
BIODESIX LAB ACCESSION NUMBER: (To be completed by biodesix)

## 5. BILLING/PAYMENT INFORMATION

SUBMITTING DIAGNOSIS:	ICD-9 CODE:		
METHOD OF PAYMENT:			
<input type="checkbox"/> INSURANCE* <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> UNINSURED <input type="checkbox"/> SELF PAY	If uninsured, call (866) 432-5930 to have patient assistance program application faxed to physician.		
MEDICARE ONLY:			
<input type="checkbox"/> NON-HOSPITAL PATIENT <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT (>24 HR STAY) DISCHARGE DATE:			
NAME OF INSURED* LAST	FIRST	MI	DOB OF INSURED: MM/DD/YYYY
RELATIONSHIP TO INSURED:			
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> OTHER (PLEASE SPECIFY):			
PRIMARY INSURANCE NAME:		SUBSCRIBER ID #:	
GROUP #:		PRIOR AUTHORIZATION NO.:	
INSURER PHONE NO.:		INSURER FAX NO.:	
SECONDARY INSURANCE: <input type="checkbox"/> YES* <input type="checkbox"/> NO			
*Please attach a copy of the front and back of patient's insurance card for both primary and secondary insurers			

## 6. PHYSICIAN CERTIFICATION

Your signature constitutes a certification of medical necessity and a certification that you have obtained the patient's consent for Biodesix release of test results to the third party payor when necessary as part of the reimbursement process.

SIGNATURE OF ORDERING PHYSICIAN

DATE:

