Quest National Account #: 97513526

ASPiRA LABS® Ova1
YOUR HEALTH. OUR PASSION.

12117 Bee Caves Rd. Building III, Suite 100 Austin, TX 78738
Tel: (844) 277-4721 Fax: (866) 283-3634 e-mail: support@ASPiRALAB.com

Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

Collection Date: _____ **Phlebotomist Initials:** _____ ☐ Physician Office ☐ Draw Site ☐ Other

TEST REQUEST FOR OVA1

☑ **VDS-100** [FEMALE SERUM ONLY] Ova1 The OVA1 test from ASPiRA LABS to assess the likelihood that an ovarian mass is malignant prior to planned surgery.

PHYSICIAN INFORMATION

Physician name(s): _____ NPI#: _____

Name/Account #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Fax copy to: _____

PATIENT INFORMATION

Last name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ DOB (mm/dd/yy): __ __ / __ __ / __ __ __ __

Phone number: _____

CLINICAL INFORMATION

Menopausal Status: ☐ Pre-Menopausal ☐ Post-Menopausal

Size of mass (longest dimension): _____

Height: _____ Weight: _____ Date of last menstrual period: _____

PATIENT AUTHORIZATION

I authorize ASPiRA LABS Inc. to release medical information related to services provided herein and authorize payment directly to ASPiRA LABS Inc. I agree to assume responsibility for payment of charges that are not covered by my healthcare insurer.

***(Patient signature required for verification of benefits)*

**Patient's Signature: _____

Print Name: _____ Date: _____

PHYSICIAN SIGNATURE

I have provided informed consent for the above ordered test.

Physician's Signature: _____

Print Name: _____ Date: _____

BILLING INFORMATION

Bill the Following (required):

☐ Private Insurance ☐ Medicare* ☐ Patient Self-Pay ☐ Medicaid ☐ Ordering Facility (Client Bill)

* By ordering this test for your medicare patient, your patient has met the requirements for use i.e. has an ovarian mass, has surgery planned and is over 18 years of age.

Insurance Information: Attach a copy of front and back of patient insurance card and complete.

Primary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Secondary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Name of insured: Last: _____ First: _____ DOB: _ _/ _ _/ _ _ _ _

Relationship to insured:
☐ Self ☐ Spouse ☐ Dependent ☐ Other

DIAGNOSIS CODES | ICD-10 Codes (check all that apply):

- ☐ N83.201 Unspecified ovarian cyst, right side+
- ☐ N83.209 Unspecified ovarian cyst, unspecified side+
- ☐ R19.03 Right lower quadrant abdominal swelling, mass and lump+
- ☐ R19.05 Periumbilical swelling, mass and lump+
- ☐ N83.202 Unspecified ovarian cyst, left side+
- ☐ R19.00 Intra-abdominal and pelvic swelling, mass and lump, unspecified site+
- ☐ R19.04 Left lower quadrant abdominal swelling, mass and lump+
- ☐ R19.09 Other intra-abdominal pelvic swelling, mass and lump+

Other ICD-10 Codes: _____ _____ _____ _____ _____ _____

+ This is provided for informational purposes only and is not a guarantee of coverage. It is the provider's responsibility to determine the appropriate codes.

ENROLLMENT REQUIRED FOR VERIFICATION OF BENEFITS

For enrollment and additional information, call (866) 927-7472

Prior to sending specimen, fax this form to: 844-965-9285

External PSC or Draw Center
☐ **Please contact patient with insurance benefits prior to Blood Draw**

In-Office Phlebotomy Draw Use
☐ **HOLD SPECIMEN at LAB pending benefits check and patient approval**