ASPiRA LABS
A VERMILLION COMPANY

Patient Test Requisition Form

OVA1117522

STEP 1: Patient to Complete Requested Information

Fields in ***RED*** are critical to avoid processing delays

TEST REQUEST

☑ VDS-100 Ova1

OVA1 test from ASPiRA LABS to assess the likelihood that an ovarian mass is malignant prior to planned surgery

Serum Only

PATIENT INFORMATION

Complete Patient Information:

Last name: _____ ***First name:*** _____ MI: ____

Address: _____

City: _____ ***State:*** _____ Zip: _____

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

BILLING INFORMATION

Bill the Following (Required):

☐ Private Insurance ☐ Medicare ☐ Patient self-pay
☐ Medicaid ☐ Sending facility

Insurance Information:

Attach a copy of front and back of patient insurance card and complete. **To bill secondary insurance, attach a copy of front and back of the secondary insurance card**

Member ID#: _____ Group ID#: _____

Employer of insured: _____

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

Name of insured - Last: _____ First: _____

Primary insurance carrier: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

PATIENT AUTHORIZATION/ASSIGNMENT (Required):

I authorize ASPiRA LABS Inc. to obtain and release relevant medical and other information and to directly bill and submit claims to Medicare, Medicaid, Medicare Supplemental and/or other insurance providers for laboratory/medical services that ASPiRA LABS provides to me. I assign insurance benefits to ASPiRA LABS and acknowledge that charges that are not covered by insurance, including any applicable co-payments and deductibles, are my responsibility and I agree to pay for such charges.

Signature of Patient: _____ Print Name of Patient: _____ Date: __ __/__ __/__ __ __ __

STEP 2: Bring Test Requisition Form to Your Physician

STEP 3: Physician and Phlebotomy Use only

1. Complete all information below
2. Please go online at http://vermillion.com/providers/ova-1/how-to-order/ OR call 1-844-ASPiRA (1-844-2774721) for sample submission and shipping instructions

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

PHYSICIAN AND PATIENT INFORMATION

Patient Information:

Medical Record Number (MRN): _____

Menopausal Status: ☐ Pre ☐ Post

Date of Surgery: __ __ / __ __ / __ __ __ __

Physician Information:

Physician name(s):

NPI #: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ ***Fax results to:*** _____

Copy to: _____

BILLING INFORMATION

Diagnosis Code:

ICD-10 Codes:

☐ R19.03 Right lower quadrant abdominal swelling, mass and lump††

☐ R19.04 Left lower quadrant abdominal 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.

Physician Signature:

I affirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom or disorder, and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.

SIGNATURE OF ORDERING PHYSICIAN:

Print Name: _____ Date: __ __/__ __/__ __ __ __

Menopausal status required for patient result interpretation.

PRC000670 v 1.00

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