ASPiRA LABS® YOUR HEALTH. OUR PASSION. Ova1

12117 Bee Caves Rd. Building III, Suite 100 Austin, TX 78738
Tel: (844) 277 - 4721 Fax: (866) 283 - 2634 e-mail: support@ASPiRALAB.com

Partner Lab Barcodes

Blood draw CPT code: 36415

# Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

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

## TEST REQUEST

☐ VDS-100 [SERUM ONLY] Ova1

The OVA-1 test from ASPiRA LABS to assess the likelihood that an ovarian mass is malignant prior to planned surgery.

## PHYSICIAN INFORMATION

Physician name(s): ______________________________

NPI#: ______________________________

Gynecologic Oncology & Pelvic Surgery Associates
VA1MAG110Q
3289 WOODBURN RD sTE 320
ANNANDALE, VA 22003
Phone: 571-308-1830 Fax: 571-308-1843

Fax results to: 571-308-1843

Copy to: ______________________________

## 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.

Physician's Signature: ______________________________

Print Name: ______________________ Date: ________

## PATIENT INFORMATION

Last name: ______________ First Name: ______________

Address: ______________________________

City: ______________________________

State: ________ Zip Code: ______________

SSN: ______________________________

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

Phone number: ______________________________

Email Address: ______________________________

Medical Record Number: ______________________________

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

## PATIENT AUTHORIZATION

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.

Patient's Signature: ______________________________

Print Name: ______________________ Date: ________

## BILLING INFORMATION

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

| | | | |
|---|---|---|---|
| ☐ N83.1 Corpus luteum cyst+ | ☐ N84.0 Polyp of corpus uteri+ | ☐ R19.00 Intra-abdominal and pelvic swelling, mass and lump, unspecified site+ | ☐ R19.05 Periumbilical swelling, mass and lump+ |
| ☐ N83.0 Follicular cyst of ovary+ | ☐ N84.8 Polyp of other parts of female genital tract+ | ☐ R19.03 Right lower quadrant abdominal swelling, mass and lump+ | ☐ R19.07 Generalized intra-abdominal and pelvic swelling, mass and lump+ |
| ☐ N83.2 Other and unspecified ovarian cysts+ | ☐ M84.9 Polyp of female gential tract unspecified+ | ☐ 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.

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: Name of insured: Last: ______________ First: ______________

☐ Self ☐ Spouse ☐ Dependent ☐ Other

Primary insurance carrier: ______________________________

Address: ______________________________ City: ______________ State: ________ Zip Code: ________

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# ADVANCE BENEFICIARY NOTICE (ABN)

**NOTE: You need to make a choice about receiving these laboratory tests.**

Medicare may not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or services does not mean that you should not receive it. There may be good reason your doctor recommended it.

For questions about Medicare coverage or your potential financial responsibility for the cost of testing, please contact us at 1.844.ASPiRA1 (1.844.277.4721), and select the “billing questions” option.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- **Ask us to explain, if you don’t understand why Medicare may not cover your test.**
- **Ask us how much these laboratory tests will cost you (Estimated Cost: $_______), in case you have to pay for them yourself or through other insurance.**

**Please choose ONE option below. Check ONE box and then SIGN AND DATE.**

**Patient-signed ABN (on the backside of the original requisition form) to go to ASPiRA LABS.**
**Copy of requisition form to stay with client/office.**

☐ **Option 1. YES. I want to receive these laboratory tests.**

I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare’s decision.

☐ **Option 2. NO. I have decided not to receive these laboratory tests.**

I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare to determine if Medicare will pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

_________________ _______________________________________________

**Date** **Signature of patient or person acting on patient’s behalf**

**Patient-signed ABN (on the backside of the original requisition form) to go to ASPiRA LABS. Copy of requisition form to stay with client/office.**

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare.