



STEP 1: Patient to Complete Requested Information

TEST REQUEST



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

Serum Only

BILLING INFORMATION

Bill the Following:

- 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#: _____ Employer of insured: _____

Relationship to insured: Self Spouse Dependent Other

Name of insured - Last: _____ First: _____

Primary insurance carrier: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

PATIENT INFORMATION

Complete Patient Information:

Last name: _____ First name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

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

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

- Complete all information below
- 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 planned: ___/___/___

Physician Information:

Physician name(s): _____

NPI #: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Fax results to: _____

Copy to: _____

BILLING INFORMATION

Primary Diagnosis

Secondary Diagnosis

ICD-10 CODES: _____ ICD-10 CODES: _____

Reference ICD-10 Codes^{††}:

R19.03 Right lower quadrant abdominal swelling, mass and lump
R19.04 Left lower quadrant abdominal swelling, mass and lump

^{††}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: ___/___/___