

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-125 [FEMALE SERUM ONLY] **Ova¹+** OVA1[®]+ is a reflex test in which OVA1[®] is performed and then reflexes to OVERA[®] if the OVA1[®] result is in the intermediate range.

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: _____
Ethnicities (Check all that apply)
 Caucasian Ashkenazi Jewish Sephardic Jewish Asian
 Hispanic Native American African American
 Other: _____

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.