Ova1 plus COMPLETING A TEST REQUISITION

Please complete all parts of the requisition highlighted in red. Below are some tips to properly complete the form.

Collection Date
Fill in collection date for timely processing.

Physician Information
Please complete ordering physician and ensure all information is accurate.

Signatures
Both physicians and patients should sign the test request form.

Patient Information
Clearly complete all patient information.

Clinical Information
Check off patient's menopausal status.

Insurance Information
Ensure the patient's insurance information is complete and up to date or attach copy of insurance card, front and back.

Quest National Account #: 97513526

ASPiRA LABS — YOUR HEALTH. OUR PASSION. — Ova1 plus

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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 plus 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.

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844.277.4721 ASPiRAlab.com

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