



COLOGUARD® ORDER REQUISITION FORM

EXACT SCIENCES LABORATORIES, LLC
145 E. Badger Rd, Ste 100, Madison, WI 53713
P: 844-870-8879 | www.exactlabs.com
Fax completed form to 844-870-8875

Provider & Order Information

Recommended: type all Provider information.
Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization: _____

Provider Name: _____

NPI #:

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(or DEA # if NPI is not available)

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

*To receive results for this order, please provide secure FAX number only

TEST INFORMATION

Test Name: Cologuard

Test Description: Stool-based DNA test with hemoglobin immunoassay component

ICD-10 Code:

Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

Other(s) _____

We will not ship a collection kit to the patient if ICD-10 coding is missing. The above code is listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.

Certification

I am a licensed medical professional authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect a second sample from the patient as appropriate.

Ordering Provider Signature _____
Order

Date of _____

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan & furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights & benefits under my insurance plans to Exact & authorize Exact to appeal & contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider.

Patient Signature: _____ Date: _____

Patient Information

Attach a copy of the front & back of primary and/or secondary insurance cards.

PATIENT INFORMATION: Recommended – also attach a patient demographic sheet

Patient ID/MRN: _____

First Name: _____ Last Name: _____

DOB* (mm/dd/yyyy): ___/___/___ Sex: Male Female

*Medicare/Med Advantage coverage for patients between ages 50-85

Phone Number (required): _____

Home Mobile Work

Email address: _____

Language Preference (optional): _____

PATIENT ADDRESS

Shipping Address: _____

City, State, Zip: _____

Billing Address: _____

Same as Shipping

City, State, Zip: _____

Patient Insurance/Billing Information

Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Policyholder Name: _____ Policyholder DOB: ___/___/___ Relationship to patient: Self Spouse Other

Type: Insurance Medicare Medicare Advantage Medicaid Tricare Self-Pay

Insurance Carrier/Program: _____ Customer Service # on Insurance Card: _____

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ Group Number: _____ Plan: _____

Fax completed form to 844-870-8875

For Laboratory Use Only

Sample Collected: ___/___/___

Sample Received: ___/___/___



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