Quest National Account #: 97513526

ASPiRA LABS® YOUR HEALTH. OUR PASSION. Ova1+

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# Laboratory Test Requisition Form

*TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED*

**OVA1+ Test Request Form**

Highlighted below are some tips to properly complete the form

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

## TEST REQUEST FOR OVA1

Fill in collection date on the test request form for timely processing.

☑ **VDS-125** [FEMALE SERUM ONLY] ...rmed 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: ________________________________________

Please complete ordering physician and ensure all information is accurate.

## 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

...nc. to release medical information related to ...d authorize payment directly to ASPiRA LABS Inc. ...ility for payment of charges that are not covered

...d for verification of benefits)

## PHYSICIAN SIGNATURE

I have provided informed consent for the abov...

Both physicians and patients should complete items highlighted in red and sign the test request form.

Physician's Signature: ______________________________________

Print Name: ________________________________ Date: _______

**Patient's Signature: ______________________________________

Print Name: ____________________________ Date: ________

## BILLING INFORMATION

**Bill the Following (required):**

☐ Private Insurance ☐ Medicare* ☐ Patient Self-Pay ☐ Medicaid ☐ ...

* By ordering this test for your medicare patient, your patient has met the requirements for use i...

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

**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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