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Quest National Account #: 97513526

Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

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

TESTS REQUESTED

☐ (VDS-125)OVA1plus — OVA1®plus is a reflex test in which OVA1® is performed and then reflexes to OVERA® if the OVA1® result is in the intermediate range. This testing assesses the likelihood that an ovarian mass is malignant prior to planned surgery.

☐ **(COV-100) Anti-SARS-CoV-2 (COVID-19 Antibody Test)**

☐ **(GCP-100) Germ Cell Panel** (Includes: AFP, bHCG, LDH)

☐ **(MCP-100) Mucinous Panel** (Includes: CA19-9, CEA)

Germ Cell Tests:
☐ AFP (GCP-110)
☐ bHCG (GCP-120)
☐ LDH (GCP-130)

Mucinous Tests:
☐ CA19-9 (MCP-120)
☐ CEA (MCP-110)

PROVIDER INFORMATION

Physician name(s): ______________________ NPI#: __________
Name/Account #: ____
Address: ____
City: ___________________ State: _____ Zip Code: __________
Phone: ____________________ Fax: ________________________
Fax copy to Name: ______________________________________
Fax copy to Number:_____________________________________

PATIENT INFORMATION & AUTHORIZATION

Last name: _________________ First Name: ___________________
Address: ____
City: ____________________ State: ______ Zip Code: __________
SSN: ________________ DOB (mm/dd/yy): _ _ / _ _ / _ _ _ _
Phone number: ____
Email address: ____
Ethnicity (Check all that apply):

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian
☐ Hispanic ☐ Native American ☐ African American
☐ Other:__________________

I authorize ASPIRA LABS to release medical information related to services provided herein and authorize payment directly to ASPIRA LABS. More information is available at https://aspirawh.com/about-us/legal/ I agree to assume responsibility for payment of charges that are not covered by my healthcare insurer.

**Patient's Signature: ______________________________________
**patients signature required for verification of benefits
Print Name: ____________________________ Date: ________

PHYSICIAN SIGNATURE

Physician's Signature: _______________________________________
Print Name: ___________________________________ Date: _______

CLINICAL INFORMATION & DIAGNOSIS CODES

Menopausal Status: ☐ Pre-Menopausal ☐ Post-Menopausal Ultrasound Results: ☐ Low Risk ☐ High Risk ☐ Not Definitive

Date of last menstrual period: _____________________ Size of mass (longest dimension): __________ Height: _______ Weight: _________

DIAGNOSIS CODES | ICD-10 Codes (check all that apply):

+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.

☐ N83.201 Unspecified ovarian cyst, right side+
☐ N83.202 Unspecified ovarian cyst, left side+
☐ N83.209 Unspecified ovarian cyst, unspecified side+
☐ R19.00 Intra-abdominal and pelvic swelling, mass and lump, unspecified site+
☐ R19.03 Right lower quadrant abdominal swelling, mass and lump+
☐ R19.04 Left lower quadrant abdominal swelling, mass and lump+
☐ R19.05 Periumbilical swelling, mass and lump+
☐ R19.09 Other intra-abdominal pelvic swelling, mass and lump+

Other ICD-10 Codes: _____ _____ _____ _____ _____ _____

Does the patient:	No	Yes	If YES:
Have pain in the abdomen or pelvis?			How many days per month? ☐ 0-5 days ☐ 6-12 days ☐ >12 days For how long: ☐ <1 month ☐ 1-6 months ☐ 7-12months ☐ >12 months
Feel full quickly or unable to eat normally?			How many days per month? ☐ 0-5 days ☐ 6-12 days ☐ >12 days For how long: ☐ <1 month ☐ 1-6 months ☐ 7-12months ☐ >12 months
Experience abdominal bloating or an increased abdominal size?			How many days per month? ☐ 0-5 days ☐ 6-12 days ☐ >12 days For how long: ☐ <1 month ☐ 1-6 months ☐ 7-12months ☐ >12 months

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, you are certifying that the 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

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