Laboratory Test Requisition Form

! TO AVOID DELAYS IN REPORTING RESULTS, **THE TEXT INDICATED IN RED MUST BE COMPLETED**

Collection Date: _____ **Phlebotomist Initials:** _____ ☐ Physician Office ☐ Other ☐ Quest/PSC Site _____

STEP 1 *Select a Test*

Initial Clinical Assessment

☐ OvaWATCH℠ **VDS-130** OvaWatch℠ is intended for use as a non-invasive test to assess the risk of ovarian cancer for women with adnexal masses, evaluated by initial clinical assessment (ICA) as indeterminate or benign.

OvaWatch: (LDT) [1 SST, Tiger Top Tube]

Planned for Surgery

☐ Ova1 plus® **VDS-125** Ova1Plus® is a reflex process in which Ova1® is performed and then reflexes to Overa® if the Ova1 result is in the reflex range. This testing assesses the likelihood that an ovarian mass is malignant prior to planned surgery.

Ova1 and Overa: (FDA Cleared) [1 SST, Tiger Top Tube]

Germ Cell Tests: ☐ **AFP** (GCP-110) ☐ **bHCG** (GCP-120) ☐ **LDH** (GCP-130) ☐ **Germ Cell Panel** (GCP-100) Includes: AFP, bHCG, LDH

Mucinous Tests: ☐ **CEA** (MCP-110) ☐ **CA19-9** (MCP-120) ☐ **Mucinous Panel** (MCP-100) Includes: CEA, CA19-9

STEP 2 *Provide Clinical Info*

CLINICAL INFORMATION

Menopausal Status: ☐ **Pre-Menopausal** ☐ **Post-Menopausal** ☐ **Unknown**

Ultrasound Results: ☐ Low Risk ☐ High Risk ☐ Not Definitive

Date of last menstrual period: _____

Size of mass (greatest dimensions - cm): _____

STEP 3 *Select Physician*

PHYSICIAN INFORMATION

Physician name(s): _____ NPI#: _____

Name/Account #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Fax copy to: _____

STEP 4 *Provide Patient Info*

PATIENT INFORMATION

Last name: _____ First Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

MRN: _____ DOB (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

Mobile Phone*: _____

Home Phone: _____

Email Address: _____

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

**Providing your mobile phone will allow us to contact you via text message for billing and payment. Please note that your patient information will not be transmitted via text message. Your wireless carrier's standard data and messaging rates may apply.*

STEP 5 *Provide Insurance Information & ICD-10 Codes*

PLEASE INCLUDE A COPY OF A FACE SHEET AND INSURANCE CARD AND PROVIDE THE ICD-10 CODE.

BILLING INFORMATION

Bill the Following (required): ☐ Private Insurance ☐ Medicare* ☐ Patient Self-Pay ☐ Medicaid ☐ Ordering Facility (Client Bill)

**By ordering Ova1 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

ICD-10 Codes (check all that apply):

- ☐ 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: _____ _____ _____ _____ _____ _____

+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.

STEP 6 *Physician Signature*

PHYSICIAN AUTHORIZATION AND ACKNOWLEDGEMENT

By signing, you are attesting to the following: *(1) The information listed above is accurate clinical data. It is medically necessary to perform the test and the results will be used together with other data to help inform clinical decision making by the provider and guide treatment decisions for the patient. (2) According to the assay criteria, the patient meets the requirements. (3) The physician or physician's delegate has the authority to sign care delivery support forms and documents on behalf of the ordering physician (electronic, PA signature requirements).* ***Acknowledgment:*** *Upon signing this form, the doctor hereby acknowledges (1) that all authorizations from the patient are obtained to allow the release of medical and insurance information necessary to process claims for services. (2) Release of medical and insurance information is necessary for the processing of claims for services provided by Aspira Women's Health and to provide any medical and insurance information necessary to process claims for services provided by Aspira Women's Health. As part for the assignment of benefits, Aspira Women's Health will pursue all necessary appeals of full or partial payment prior to services being rendered by Aspira Women's Health.*

Physician's Signature: _____ Date: _____

Print Name: _____

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