

## TEST REQUISITION FORM

<b>PATIENT</b>	<b>Patient Last Name:</b>	<b>First:</b>	<b>MI:</b>	<b>Patient DOB</b>	<b>Sex</b>	<b>SSN</b>	
						Not Required	
	<b>Patient Address:</b>				<b>Patient Phone:</b>		
	<b>Patient Email:</b>						
	<b>Race:</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Pacific Islander						
<b>1. Medical History:</b> Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No <b>2. Any family history of colorectal cancer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>BILLING</b>	<b>Payment Preference:</b>		<b>Insurance Information:</b> If using insurance, complete the following section and attach a copy of front and back of patient's primary and, if applicable, secondary insurance card. Note: Billing <b>CPT Code</b> for BeScreened-CRC is <b>0163U</b> and <b>Diagnostic Codes</b> are <b>Z12.9, Z12.11, Z12.12, Z12.13</b>				
	<input type="checkbox"/> Insurance						
	Insured Last Name: _____		First Name: _____		Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse		
	Primary Insurance Carrier: _____		Employer Name: _____		<input type="checkbox"/> Dependent		
	Member ID: _____		Group Name/ID: _____		Carrier Phone Number: _____		
Secondary Insurance Carrier (if applicable): _____							
Member ID: _____		Group Name/ID: _____		Carrier Phone Number: _____			
<b>PATIENT AUTHORIZATION/ASSIGNMENT (Required):</b> I authorize Beacon Biomedical Inc. to obtain & release relevant medical and other information and to directly bill & submit claims to my insurance providers for laboratory services that Beacon provides to me. I assign insurance benefits to Beacon & acknowledge that charges not covered or exempt by insurance (e.g. no balance billing policies) including applicable co-payments & deductibles, are my responsibility & I agree to pay for such charges.							
Patient Signature: _____		Print Name: _____			Date: _____		
<b>PHYSICIAN</b>	<b>Medical Reason/Necessity:</b> I affirm this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom or disorder, and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the "Ordering Physician" space below is authorized by law to order the test(s) requested herein. Test is indicated for patients 45-85 years of age, at average risk for colorectal cancer, and who are <u>unable or unwilling</u> to participate in screening using other recommended screening tests, such as fecal-based tests or colonoscopies. Not intended for high-risk patients with family or personal history of cancer, have an inflammatory disease, patients who are pregnant or nursing, that are receiving chemotherapy or radiation, or who are less than 60-days post-surgical procedure.						
	<b>Physician Name (Printed)</b>		<b>Physician Signature</b>		<b>Date</b>		
	Michael J. Bauer, MD		-- Signature On File --				
	<b>Practice Name:</b>		<b>Practice Street Address:</b>		<b>Practice City, State, Zip Code:</b>		
	MJB Companies		200 South Wilcox Street #443		Castle Rock, CO 80104		
	<b>Practice Phone Number:</b> (833) 227-4522		<b>Reporting E-Mail Address:</b> info@cashlabs.com				
	<b>Preferred Reporting Method</b> <input type="checkbox"/> Fax <input checked="" type="checkbox"/> E-Mail		<b>Physician NPI Number:</b> 1346417086		<b>If ACO/IPA, ID &amp; Phone Number:</b>		
<b>SAMPLE</b>	<b>Date of Specimen Collection:</b>		<b>Time of Collection:</b>	<b>Phlebotomist's Initials:</b>	<b>Collection Site ID:</b>		
	/   /				Physician's Office <input type="checkbox"/> Other <input type="checkbox"/> Site ID: _____   SQL <input type="checkbox"/>		
	<b>Date of Specimen Received</b>		<b>Time Received:</b>	<b>Beacon ASSN #</b>	<b>Sonora Quest Lab Acct/Codes</b>		
/   /				<input type="checkbox"/> Beacon SQL Account No. <b>1650</b> <input type="checkbox"/> Pass-through Code <b>906874</b>			

### Blood Draw Patient Service Center Locations

**Arizona:** At any Sonora Quest Laboratories Patient Service Center Location; visit: <https://www.sonoraquest.com/find-a-location/>  
**States Other Than Arizona:** Contact Beacon Biomedical for coordination of the blood draw at: 1-480-757-9037 (Office). BeScreened<sup>™</sup>-CRC is available as a CLIA Reference Laboratory Developed Test (LDT) through Beacon Biomedical only (CLIA Lab No. 03D2122615) in all states except CA and NY.