

## 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: \_\_\_/\_\_\_/\_\_\_\_\_