

DIRECTHIT™ TEST PANEL FOR BREAST CANCER REQUISITION FORM
Drug Response Indicator Test

Patient Name:	First	Middle	Last	Date of Birth-MM/DD/YYYY
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I. ACCOUNT INFORMATION		<input type="checkbox"/> First submission <input type="checkbox"/> Resubmission
*Ordering Physician (Print Name):		Hospital/Institute:
*Ordering Physician Signature:		Address
*Ordering Physician E-mail:		
*Ordering Physician Tel. #:	Fax #:	City: State: ZIP
Send report to Physician's <input type="checkbox"/> E-mail above <input type="checkbox"/> Address <input type="checkbox"/> Fax <input type="checkbox"/> Special instructions below		
Special instructions:		

II. PATIENT INFORMATION (Required)			
Patient ID/Slide #	Gender	Race	Date of Birth
	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> AA <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> Other	
Disease Status (Check One): <input type="checkbox"/> Progressive <input type="checkbox"/> Complete Remission <input type="checkbox"/> Partial Remission <input type="checkbox"/> Stable			
Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Hormonal Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No			

III. Billing Information	
Submitting Diagnosis	Code
Patient Self Pay credit card <input type="checkbox"/> on account <input type="checkbox"/> not applicable <input type="checkbox"/>	Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/>
Name on Credit Card	<input type="checkbox"/> In-Patient <input type="checkbox"/> Outpatient
CC #	Exp. Date
<input type="checkbox"/> non-Hospital Patient <input type="checkbox"/> Signed ARN attached	
Patient Signature Authorization to bill credit card _____ Date _____	
Private Insurance <input type="checkbox"/> Complete Page 2	

IV. Pathology Information (Required)		
Tissue Collection Date (required)	Body Site:	Paraffin Block ID #
Primary Diagnosis: <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Other:	ICD-9 / ICD-10 _____	
Stage _____ Grade: _____ T: _____ N: _____ M: _____ G: _____ /	<input type="checkbox"/> In-Situ <input type="checkbox"/> Invasive <input type="checkbox"/> Ductal <input type="checkbox"/> Lobular Metastatic <input type="checkbox"/> yes <input type="checkbox"/> no	
Tumor Size: (cm)	Nodal status (positive/Total):	
Slide Preparation Date :	# of unstained slides for test: <input type="checkbox"/> 6 <input type="checkbox"/> other	
Pathologist	Tel #	Fax #
Pathologist Signature	Date	e-mail

*These diagnostic laboratory tests must be ordered by a treating physician (or their authorized representative) who is providing consultation or treatment recommendations for a patient with breast cancer. Signature of the physician above certifies that intention to treat or not to treat with chemotherapy is contingent, at least in part, on the results of this series of tests. If the ordering physician is not the treating physician, then the ordering physician who signs this form confirms that the treating physician has ordered the DirectHit™ Test Panel for Breast Cancer.
**This test was developed and its performance characteristics determined by CCC Diagnostics LLC. The analyte-specific reagents utilized in the test procedure have not been cleared by the U.S. Food and Drug Administration (FDA) nor does the FDA require user certification for their use. This service is an adjunct to the clinical evaluation of the referring physician and does not represent a final diagnosis. Its role in the management of individuals is left to the discretion of the referring physician.

CCCD Use Only			
Patient Last Name:	Confirmation #	Account No.	
Sample must be received by: _____ to meet scheduled Test Date _____ Turnaround time: 6 business days.			
Date/Time Rec'd:	Accession No.	Within Limits: <input type="checkbox"/> yes <input type="checkbox"/> no	Rec'd By: _____

INSURANCE VERIFICATION / AUTHORIZATION SHEET

Patient: _____ Date of Birth: _____

SS# _____ Referring Physician _____

Reason for Test: _____

Test Facility: _____

PRIMARY INSURANCE COMPANY _____ Phone # _____

Policy # _____ Group # _____ Effective Date _____

Claims Mailing Address: _____

Verification Date: _____ Verified by: _____

Spoke To (full name): _____

Co-Pay: _____ Need a REFERRAL? ____ YES ____ NO Certification? ____ YES ____ NO

Authorization? ____ YES ____ NO Authorization # _____

Are there any Pre-Existing Conditions? ____ YES ____ NO

What are the conditions? _____

Is the pre-existing condition less than 30 days old? ____ YES ____ NO

Is there a "Wait Time" due to any investigations pending or otherwise? ____ YES ____ NO

TREATMENT PLAN REQUIRED? Y N LENGTH OF TIME : _____

SECONDARY INSURANCE COMPANY _____ Phone # _____

Policy # _____ Group # _____ Effective Date _____

Claims Mailing Address: _____

Spoke To (full name): _____ Co-Pay?: _____

PATIENT'S AUTHORIZATION

I authorize the release of medical information to insurance carriers and / or their agents. I also authorize payment of medical benefits to the physician or supplier for services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent.

I understand that if a service is not a covered benefit and that without an authorization or referral form from my HMO/IPA/PPO, I will be financially responsible for charges I incur in full.

SIGNATURE OF SUBSCRIBER

DATE

ATTACH FRONT AND BACK COPIES OF INSURANCE CARD

ATTACH COPY OF DRIVERS LICENSE

CCCD Use Only Patient Last Name: _____ Confirmation # _____ CCCD Accession # _____
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