

BBDRisk Dx® Test Request Form

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Section 1. Submission Status

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X First Submission Resubmission-Associated Requisition #	
Section 2. Physician Information	Section 3. Physician Signature
Practice Account Details: Address: Breast Center, 111 Main Street, City, State, Zip code: 00000 Phone: 555-000-0000 Fax: 555-000-0001 Ordering Physician Name: Jane Jones, M.D Contact Name: Ms. Smith Contact Phone: 555-000-0002 Contact email: smithXXXXX@university hospital.edu Send Report by: Mail □ Fax □ email X□	I represent that I am treating this patient as the physician of record and authorizing the performance of the test identified on this order. I have concluded that the test I am ordering is medically necessary for treatment of this patient. I anticipate that the test will provide predictive information which has not been obtained already. This order form is part of the medical record, is consistent with other entries in the record and accurately describes the reason I am ordering the test. In submitting this order, I acknowledge that I have obtained the consent from the patient for Silbiotech, Inc. to release the test results to the patient's third party payer when necessary as part of the reimbursement process. I have read and agree to be bound by Silbiotech, Inc.'s general us and conditions. Ordering Physician Signature: Jones, M.D. Date: 7/7/2017 Name: Jane Jones, M.D.
Section 4. Patient Information	Section 5. Billing Information
Doe, Missie S.	Complete the following and attach a copy of front and back of insurance card Billing Type: X Private Insurance Medicare Patient Work-place insurance XYZ123 Primary Insurance Name Member ID 12X45V 555-555-7777 Prior Authorization # (if available) Phone Second Insurance ABC575 Secondary Insurance Name Member ID Relationship to Insured: X self (skip section below) Spouse Dependent Other: Insured DOB Insured SSN
Collection Date: 6-6-2017 Specimen Type: \square FFPE Block $X\square$ FFPE Slides $X\square$ Right Breast \square Left Breast: Submitting Diagnosis (check all that apply): $X\square$ ADH $X\square$ ALH \square UDH \square PAPILLOMA \square Sclerosing Adenosis Please include Pathology Report with the Test Request Form and an H& E slide from the selected block(s)	
Section 7. Pathology Information	
Practice Account Details: Address: Pathology Labs, 354 Elm Street, City, State, Zip: Phone: 555-222-5555 Fax: 555-222-5556 Submitting Pathologist Name: Doctor Doctor, M.D Block Return Location (If different): Phone: Contact Name:	Specimen ID(s): 1) S-06980 2) S-246789 6-6-2017 Date of Surgery Date Pulled from Archives Additional comments