PROphetNSCLC® by ONCOHOST
GUIDED ONCOLOGY

OncoHost Inc. | Email: contact@oncohost.com
Client Services: 1-855-950-2112 | Fax: 1-919-415-1308

TEST REQUISITION FORM
Please fill out all relevant fields below

ORDER ID:
For OncoHost use only

PATIENT KIT ID:
Place kit label here

TEST ORDERING INSTRUCTIONS
1. Complete all fields below. Ordering provider MUST sign and date this form to authorize the order.
2. Attach copies of all available pathology reports.
3. Attach patient face sheet and copy of insurance card(s) (front and back) for primary and secondary insurance.
4. Have patient sign page 2 of this form at the time of test ordering or blood draw.
5. Fax TRF with required documents to 1-919-415-1308.
6. To order via our physician portal, go to www.oncohost.com and click 'Order a test.'

1. TEST REQUESTED
☐ PROphetNSCLC® test

2. ELIGIBILITY CRITERIA FOR PROPHET® TEST
Newly diagnosed, first line, metastatic NSCLC

3. BLOOD DRAW TO BE COMPLETED BY (select one)
☐ In-clinic ☐ Mobile Phlebotomy

FOR IN-CLINIC BLOOD DRAWS ONLY			
	Lab Contact Name	Lab Phone	Lab Fax
	Lab Email	Expected Blood Draw Date	

4. ORDERING PHYSICIAN/PROVIDER

First Name	Middle Name	Last Name	NPI
Email		Phone	Fax
Medical Facility		Address	
City	State	Zip Code	

ADDITIONAL CONTACT FOR ORDER NOTIFICATIONS		
	Name	Phone
	Email	

I certify the following: I hereby request and authorize OncoHost to utilize the enclosed information to process the blood specimen for the indicated patient; the information is accurate; I am authorized by law to order the test indicated above and my signature constitutes a certification of medical necessity and patient's eligibility for the test; the test results will be used in determining treatment management of the patient's therapeutic selections including immunotherapy and chemotherapy; and I have obtained any patient consent legally required for a) performing the test and b) disclosing test results to me, and to any third party if required for payment. I agree to provide the necessary information and medical records required to support billing or reimbursement. By including the patient's mobile number, I confirm the patient has agreed to receive SMS communications for administrative purposes related to scheduling and testing. Although we take precautions, SMS communications may be subject to interception. I have read the statement of medical necessity on page 2 of this form and the Terms of Use available at https://oncohost.com/terms-of-use/ and agree on behalf of my medical practice, hospital, or other organization to be bound by this form and the Terms of Use.

Physician/Provider Signature	Printed Name	Date

5. PATIENT INFORMATION

First Name	Middle Name	Last Name
Sex ☐ Female ☐ Male	DOB	Phone
Email	Address	
City	State	Zip Code

6. ADDITIONAL PATIENT CONTACT INFORMATION (optional)
IF CAREGIVER INFO DIFFERS FROM SECTION 5, PLEASE PROVIDE CONTACT DETAILS BELOW

Primary Contact Name	Phone

7. ADDITIONAL COMMENTS

8. ICD-10 CODE(S)
Select all codes that may apply (see reverse side for descriptions; please provide the codes with the greatest specificity).

☐ C34.00 ☐ C34.01 ☐ C34.02 ☐ C34.10 ☐ C34.11 ☐ C34.12 ☐ C34.2 ☐ C34.30
☐ C34.31 ☐ C34.32 ☐ C34.80 ☐ C34.81 ☐ C34.82 ☐ C34.90 ☐ C34.91 ☐ C34.92 ☐ Other _____

9. BILLING INFORMATION (Please attach a copy of the front and back of the patient's insurance card and the patient face sheet)
☐ Insurance ☐ Medicare ☐ Medicaid ☐ Hospital/Institution ☐ Indigent ☐ Self-Pay (please contact Client Services for billing information)

Patient Status at Blood Draw (Medicare only) ☐ Hospital Inpatient Date of Discharge _____ ☐ Hospital Outpatient ☐ Non-hospital Patient

Primary Insurance	Policy #	Group #
Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		☐ Insured address same as patient address

Insured Name	Insured DOB	Insured Phone	
Address	City	State	Zip Code

10. STATEMENT OF MEDICAL NECESSITY

Medical Professional Consent

As may be required by applicable state laws and regulations, I have informed the patient regarding proteomic testing, and the patient has consented to the tests ordered. I understand that OncoHost is relying on the diagnosis or diagnosis code I have provided on the test requisition form in providing information about potential therapeutic options and clinical trials associated with the reported testing results, and that an incorrect diagnosis or diagnosis code would adversely affect the relevance of the information provided by OncoHost. I understand that I remain free in my medical decisions on how to use the results of any OncoHost product(s) in the management of this patient. I have obtained the patient's written consent to transmit the health data on this requisition form for the purpose of processing this order and performing all ordered OncoHost tests. I authorize OncoHost to request and follow-up with the patient to obtain a subsequent blood sample if an additional OncoHost test is ordered.

I hereby authorize OncoHost to release test results and relevant medical information to the patient's insurance carrier for reimbursement purposes. I have obtained the patient's consent for OncoHost to submit and, if necessary, appeal claims on the patient's behalf, as well as for OncoHost to receive payment directly from the patient's insurance provider. I understand that Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. With respect to tests reimbursed by Medicare, Medicaid or other third-party payers, I attest that all ordered OncoHost tests are medically necessary, and the results will be used in the management of the patient's condition. I agree to provide a copy of relevant clinical and medical records in order to support a request from a health plan, at no cost to OncoHost.

ICD-10 Code Reference	ICD-10 Code
Malignant neoplasm of main bronchus	
Malignant neoplasm of unspecified main bronchus	C34.00
Malignant neoplasm of right main bronchus	C34.01
Malignant neoplasm of left main bronchus	C34.02
Malignant neoplasm of upper lobe, bronchus or lung	
Malignant neoplasm of upper lobe, unspecified bronchus or lung	C34.10
Malignant neoplasm of upper lobe, right bronchus or lung	C34.11
Malignant neoplasm of upper lobe, left bronchus or lung	C34.12
Malignant neoplasm of middle lobe, bronchus or lung	**C34.2**
Malignant neoplasm of lower lobe, bronchus or lung	
Malignant neoplasm of lower lobe, unspecified bronchus or lung	C34.30
Malignant neoplasm of lower lobe, right bronchus or lung	C34.31
Malignant neoplasm of lower lobe, left bronchus or lung	C34.32
Malignant neoplasm of overlapping sites of bronchus and lung	
Malignant neoplasm of overlapping sites of unspecified bronchus or lung	C34.80
Malignant neoplasm of overlapping sites of right bronchus or lung	C34.81
Malignant neoplasm of overlapping sites of left bronchus or lung	C34.82
Malignant neoplasm of unspecified part of bronchus or lung	
Malignant neoplasm of unspecified part of unspecified bronchus or lung	C34.90
Malignant neoplasm of unspecified part of right bronchus or lung	C34.91
Malignant neoplasm of unspecified part of left bronchus or lung	C34.92

11. PATIENT ASSIGNMENT OF BENEFITS

I hereby assign and convey all applicable health insurance benefits and/or insurance reimbursement, as well as all rights and obligations that I have under my health plan, to OncoHost for services performed by OncoHost. I appoint OncoHost as my authorized representative to:

- File medical claims with my health plan;
- File appeals and grievances with my health plan;
- File appeals or grievances with an external review committee at a state insurance board, independent review organization, Office of Personnel Management, Department of Labor or equivalent agency;
- File a complaint, regarding inaccurate claims processing, appeal processing or pricing to CMS or their agent regarding my Medicare Part C plan;
- Release medical and insurance information necessary to process claims or appeals;
- Obtain medical records related to services provided by OncoHost;
- Collect payment of any and all medical benefits and insurance proceeds directly from my health plan (including Medicare and Medicaid); and
- Resolve any insurance-related matter regarding a service provided by OncoHost directly with my health plan.

I acknowledge and agree that I remain responsible for applicable co-payments, deductibles and co-insurance as required by my medical and/or other healthcare benefits plans. If I receive payment of medical and/or other health benefits on account of services provided by OncoHost, I will make the full payment to OncoHost as detailed above.

12. OUT-OF-NETWORK DISCLOSURE

I understand that OncoHost's services may be designated as out-of-network services by some insurance plans. As a result, there may be costs associated with these services that are not covered by my insurance plan. I hereby consent for out-of-network services to be provided by OncoHost.

13. AUTHORIZATION RELEASE

I hereby authorize OncoHost to:

- Obtain my blood sample and perform laboratory testing ordered by my physician;
- Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments;
- Process and submit insurance claims generated during examination or treatment; and
- Allow a photocopy of my signature to be used to process insurance claims, payment, grievances, or appeals.

This authorization will remain in effect until revoked by me in writing.

14. PATIENT CONSENT

By signing below, you agree to the terms listed in sections 11, 12 and 13 above.

Printed Name	Patient Signature	Date

☐ Subject to obtaining appropriate legal approval, OncoHost may use your remaining de-identified specimen for internal quality control, research and development purposes. Tick the checkbox if you **do not** wish to have your specimen used for future research.