PRECHECK HEALTH SERVICES, INC.
100 Biscayne Blvd., Suite 1611, Miami FL 33132
Phone: (305)-203-4711 **CLIA:** 10D2210020
appointment@precheckhealth.com www.precheckhealth.com

SolidTumorCheck+ Requisition & Statement of Medical

1. PATIENT INFORMATION

Last Name | First Name

DOB (yyyy/mm/dd) | Sex ☐ F ☐ M | Medical Record Number

Street Address

City | State | Country | Zip

Preferred Contact Phone Number | Email (We will email status updates of your test)

☐ New Precheck Patient ☐ Existing Precheck Patient

2. SPECIMEN INFORMATION

Collection Date (yyyy/mm/dd) | Name of Person Collecting Specimen

3. ICD 10 CODE(S)

4. STAGE (REQUIRED)

Patients not eligible for systemic therapy or Stage I/II not currently accepted

☐ Advanced Cancer (Stage IIIB/IV-NSCLC, Stage III/IV-other cancer types)

Currently on Therapy? If yes, please list below ▶

5. ORDERING PHYSICIAN (or other Licensed Medical Professional)

Last Name | First Name

Email

Medical Professional Consent
My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order Precheck Health Services, Inc. to perform genetic testing and curation for this patient as indicated on this requisition. I have reviewed the medical consent on the back of this form and will provide test interpretation to the patient as appropriate.
(continued on back)

Medical Professional Signature | Date

X

6. TEST SELECTION (MUSTchooseone)

☐ SolidTumorCheck+

7. ADDITIONAL RECIPIENT

Medical Professional Name

Phone Number | Fax Number

8. DIAGNOSIS (MUSTchooseone)

Date of Original Diagnosis (yyyy/mm/dd)

BRAIN
- ☐ Glioblastoma
- ☐ Other Primary CNS Tumor ▶

BREAST
- ☐ Breast Carcinoma

GENITOURINARY
- ☐ Bladder Carcinoma
- ☐ Prostate Adenocarcinoma
- ☐ Renal Cell Carcinoma
- ☐ Renal Pelvis Urothelial Carcinoma

GI
- ☐ Appendiceal Adenocarcinoma
- ☐ Cholangiocarcinoma
- ☐ Colorectal Adenocarcinoma
- ☐ Esophageal Squamous Cell Carcinoma
- ☐ Gastric Adenocarcinoma
- ☐ Esophageal/Gastroesophageal Junction Adenocarcinoma
- ☐ (GIST) Gastrointestinal Stromal Tumor
- ☐ Hepatocellular Carcinoma
- ☐ Pancreatic Ductal Adenocarcinoma
- ☐ Pancreatic Neuroendocrine Tumor
- ☐ Other Gastrointestinal Tumor ▶

GYNECOLOGIC
- ☐ Cervical Squamous Cell Carcinoma
- ☐ Endometrial Carcinoma
- ☐ Ovarian Carcinoma

HEAD & NECK
- ☐ Squamous Cell Carcinoma

LUNG
- ☐ Adenocarcinoma (NSCLC)
- ☐ Large Cell Carcinoma (NSCLC)
- ☐ Squamous Cell Carcinoma (NSCLC)
- ☐ Lung Carcinoid/Neuroendocrine
- ☐ Small Cell Lung Carcinoma
- ☐ Other Lung Tumor ▶

SARCOMA
- ☐ Sarcoma, please specify ▶

SKIN
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma

THYROID
- ☐ Thyroid Carcinoma

OTHER
- ☐ Carcinoma of Unknown Primary (CUP)
- ☐ Other ▶

9. RELEVANT CLINICAL HISTORY(ALLREQUIREDformedical coverage determination)

1. The patient is seeking further treatment and is:	☐ Newly diagnosed (Stage III/IV)	☐ Not responding to therapy	
2. Has the patient received a PCHS report since their most recent progression?	☐ No	☐ Yes	
3. Is tissue-based comprehensive genomic profilling (CGP) from a recent biopsy feasible?	☐ No	☐ Yes	
4. Has tissue-based CGP from a recent biopsy been performed with a non-QNS result?	☐ No	☐ Yes	
5. Has tissue-based CGP from a recent biopsy already returned an actionable result?	☐ No	☐ Yes	

10. BILLING INFORMATION Please attach a copy of the front and back of the patient's insurance card and/or the patient face sheet

Patient Status (Medicare only) ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital Patient

☐ Insurance (please fill in below) ☐ Medicare - Part B ☐ Medicaid ☐ Hospital/Institution ☐ Self-Pay (Please contact Client Services for billing information)

Primary Insurance	Insured Name	Policy #	Group #
Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured DOB		

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Test Requisition & Statement of Medical Necessity *continued*

5. Medical Professional Consent *(continued from front)*

As may be required by applicable state laws and regulations, I have supplied information to the patient regarding somatic genomic testing, and the patient has givenconsent for this testing to be performed by PreCheck Health Services, Inc. (PCHS) and for the results to be reported back to me. I understand that PCHS is relying only on the diagnosis or diagnosis code that I provide on the test requisition form in providing information about potential therapeutic options and clinical trials associated with the reported genomic testing results, and that an incorrect diagnosis or diagnosis code would adversely affect the relevance of the information provided by PCHS. I understand that I remain free in my medical decisions on how to use the results of SolidTumorCheckK+ test in my management of this patient.
I have obtained in writing the patient's data privacy consent to transmit the health data on this requisition form for the purpose of processing this order and performing the SolidTumorCheckK+ test. I authorize PCHS to select the most appropriate test.

I hereby authorize PCHS to release test results and relevant medical information to the patient's third-party payer, when necessary, as part of the reimbursement process. I have obtained the patient's consent for PCHS to submit claims and, if necessary, to appeal claims on the patient's behalf to pursue reimbursement, as well as for PCHS to receive payment directly from the patient's insurance carrier. 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 PCHS testing is 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 history and medical records in order to support a request from a health plan, at no cost to PCHS. I acknowledge that patients who are United States residents may be enrolled in PCHS Access, PCHS's Financial Assistance Program only if they sign the assignment of benefits form.

For Medicare Beneficiaries Only

If SolidTumorCheckK+ test is ordered: a Medicare Advance Beneficiary Notice (ABN) must be submitted for any Medicare patient for whom has previously had a SolidTumorCheck+ test and has not progressed since the previous test was performed. If SolidTumorCheckK+ is ordered: a Medicare Advance Beneficiary Notice (ABN) must be submitted for any Medicare patient for whom the questions in Section 9 on the previous page are marked in the following manner: NSCLC patients, an ABN is required if (1) question 2 is marked "Yes" or (2) if question 5 is marked "Yes" or (3) if tissue-based CGP from a recent biopsy was feasible but not performed; non-CNS solid tumor patients other than NSCLC, an ABN is required if any question is marked "Yes"; all CNS patients require an ABN. ABN forms that have been pre-populated with PCHS tests/prices can be obtained from PCHS ABN forms can be sent to PCHS with the kit/sample, via emailed to: appointment@precheckhealth.com

Patient Assignment of Benefits Form (required)

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 PCHS. for services performed by PCHS. I appoint PCHS. 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 PCHS when it is required to process a claim or appeal;
- Collect payment of any and all medical benefits and insurance proceeds directly from my health plan (including Medicare and Medicaid);
- Resolve any insurance related matter regarding a service provided by PCHS 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 PCHS I shall pay PCHS. the full amount of that payment.

AUTHORIZATION RELEASE

I hereby authorize Precheck Health Services, Inc. to

- Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments;
- Process and submit insurance claims generated in the course of 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.

OUT-OF-NETWORK DISCLOSURE AND PATIENT CONSENT

I understand that PCHS may be designated as an out-of-network service 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 PCHS.

PCHS will provide upon request, the estimated amount that PCHS expects to bill for services associated with out-of-network plans.

ERISA AUTHORIZATION

I hereby designate, authorize, and convey to PCHS, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, the following:

- The right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action against my health plan that I may have under such insurance policy and/or benefit plan; and
- The right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including, but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I understand I can revoke this authorization in writing at any time.

A photocopy of this Authorization shall be as effective and valid as the original.
This form is not an Advanced Beneficiary Notification (ABN).
If you have any questions, please do not hesitate to contact us at 1.305.203.4711 or appointment@precheckhealth.com

×	PRINT NAME OF PATIENT _____ DATE _____
SIGNATURE OF PATIENT	EMAIL _____