EsoGuard
esophageal DNA test

Test Requisition

HIGHLIGHTED FIELDS ARE REQUIRED

Patient Information

First Name: _____ Last Name: _____

Patient ID/MRN: _____

DOB (mm/dd/yyyy): _____ Sex: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email: _____

Indicate preferred language if not English: _____

Indicate the patient's BE/EAC risk factors warranting testing:
(≥3 must be checked, for test to be indicated)

- ◯ Chronic gastroesophageal reflux disease (GERD)
- ◯ Age ≥50
- ◯ White race
- ◯ Male
- ◯ Obesity
- ◯ History of tobacco smoking *(either former or current)*
- ◯ Family history of BE or EAC in a first degree relative

Is the patient a Firefighter? ◯ Yes ◯ No

Insurance Information

Please provide a copy of the front & back of the patient's insurance card.

Bill: ◯ Insurance ◯ Medicare/Medicaid ◯ Self-Pay/No Insurance ◯ Client Bill

Primary Insurance

Insurance Carrier:

Subscriber ID/Policy Number:

Group Number:

Name of Insured *(If different than patient)*:

Relationship to Patient:

◯ Self ◯ Spouse ◯ Child ◯ Other

Secondary Insurance

Insurance Carrier: _____

Subscriber ID/Policy Number: _____

Group Number: _____

Name of Insured *(If different than patient)*: _____

Relationship to Patient:

◯ Self ◯ Spouse ◯ Child ◯ Other

Prior Authorization Number: _____

Submit completed forms via fax or email:

Fax: 949.593.0191
Email: ClientServices@LucidDx.com

Client/Practice Information

Client/Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Secure Fax Number: _____

Contact Email: _____

Ordering Provider: _____

NPI Number: _____

Clinical Information

Please attach medical records and/or clinical history.
All diagnoses should be provided by the Ordering Provider or an authorized designee. Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required).

ICD-10-CM (List all applicable)

◯ K21.9 (GERD w/o esophagitis) ◯ K22.9 (Disease of esophagus, unspecified)

◯ Other(s): _____

_____

Test & Specimen Information

EsoGuard Esophageal DNA Test

Specimen Type: Cell samples collected from the distal esophagus utilizing the EsoCheck device.

All other specimens will be rejected. No pour-offs accepted.

Collection date: ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

Sample collected by: _____ (FIRST NAME LAST NAME)

Authorization and Certification of Medical Necessity

My signature constitutes a certification of medical necessity and intent to consider and use the results of the ordered test(s) with other clinical data to help determine the appropriate treatment plan for the patient. I am the patient's treating provider and the information on this form is true and correct. I explained to the patient the nature and purpose of the test performed and have obtained patient informed consent to the extent required under applicable law, to permit LucidDX Labs to perform the test, release test results, and to use the results and/or patient information for reimbursement purposes.

_____ _____

Physician/Authorized Signature **Date**

Lucid Personnel Use Only

Order Received & Reviewed by: _____ Date: _____

Lab Received Date/Tech: _____ _____

Tracking Number: _____

EG Lot#: _____ EG Exp Date: _____