EsoGuard
esophageal DNA test

Test Requisition

HIGHLIGHTED FIELDS ARE REQUIRED

Patient Information

First Name: _____ **Last Name:** _____
Legal Name (as shown on government ID)

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:

◯ Chronic gastroesophageal reflux disease (GERD)

(≥3 must be checked, for test to be indicated)

◯ 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

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)
◯ 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 Lucid Dx 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:** _____