TruDiagnostic™
The Epigenetic Company

TRUDIAGNOSTIC REQUISITION FORM

881 Corporate Dr. Lexington, KY 40503
(888) 909-3634 *
* Mon-Fri 9am-7pm | Sat 9am-3pm
Eastern Time (UTC-5:00)

Provider & Order Information

Recommended: type all Provider information. Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization Name: _____

Provider Name: _____

NPI #: | | | | | | | | | | |

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____
*To receive results for this order, please provide **secure** FAX number only

ORDER INFORMATION

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

SELECT TEST

○ ASCVD ○ COPD ○ Alzheimer's & Other Dementias
○ Major Depressive Disorder ○ Schizophrenia ○ Bipolar Disorder
○ Multiple Sclerosis ○ Parkinson's ○ NASH ○ Osteoporosis
○ Lyme ○ Hepatocellular Carcinoma

CERTIFICATION

I am a licensed healthcare provider authorized to order the DNAm Disease Diagnostic Test. This test is medically necessary and the patient is eligible to use DNAm Disease Diagnostic Test. I will maintain the privacy of test results and related information as required by HIPAA. I authorize TruDiagnostic to obtain reimbursement for DNAm Disease Diagnostic Test. and to directly contact and collect additional samples from the patient as appropriate.

_____ _____
Ordering Provider Signature **Date of Order**

Patient Demographics

Attach a copy of the front & back of primary and/or secondary insurance cards.

Patient ID/MRN: _____

First Name: _____

Last Name: _____

DOB *(mm/dd/yyyy)*: | | / | | / | | | | |

Sex: ○ Male ○ Female

Email: _____

Phone Number *(required)*: _____
○ Home ○ Mobile ○ Work

☐ *By checking this box, I confirm that Patient has consented to receive calls or text messages from TruDiagnostic concerning general CRC screening updates, reminders to screen again for CRC, and other healthcare and general account information.*

*NOTE: If this box is **not checked**, TruDiagnostic **will still** be able to provide reminders / notifications to Patient via phone call or text message about their current* DNAm Disease Diagnostic Test *order or test results. If Patient wishes to receive no communications, they may contact* (888) 909-3634 * *to update their preferences.*

Language Preference:
○ English ○ Spanish ○ Other

Shipping Address: _____

PO Box / Apt #: _____

City, State, Zip: _____

Billing Address: _____
☐ *Same as Shipping*

_____

City, State, Zip: _____

PATIENT ETHNICITY AND RACE

The completion of this section is optional.

Is your patient of Hispanic or Latino origin or descent? ○ Yes ○ No

Please mark one or more to indicate your patient's race:

○ White ○ Black or African-American ○ Asian ○ Native Hawaiian or other Pacific Islander ○ American Indian or Alaska Native

Patient Insurance/Billing Information

Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Does patient wish TruDiagnostic to bill their insurance? ○ Yes *(complete below)* ○ No *(patient will self-pay)*

Policyholder Name: _____ Policyholder DOB *(mm/dd/yyyy)*: | | / | | / | | | | |

Relationship to patient: ○ Self ○ Spouse ○ Other

Primary Insurance Carrier: _____ Type: ○ Private ○ Medicare Advantage ○ Medicaid ○ Tricare

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ Group Number: _____ Plan: _____

Prior-Authorization Code *(if available)*: _____

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

Signature not required for order to be processed

I authorize TruDiagnostic (TruD) to bill my insurance/health plan and furnish them with my DNAm Disease Diagnostic Test order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to TruDiagnostic and authorize TruDiagnostic to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider. I further understand that if I am a Medicaid enrollee in a state where TruDiagnostic is enrolled as a Medicaid provider, TruDiagnostic will accept as payment in full the amounts paid by the Medicaid program, plus any deductible, coinsurance, or copayment which may be required by the Medicaid program to be paid by me.

Patient Signature: _____ Date: _____

Fax completed form to 844-870-8875

For Lab Use Only
Sample Collected: __ /__ /____ Sample Received: __ /__ /____