



Molecular Diagnostic Test Request Form

PATIENT INFORMATION (REQUIRED)		PHYSICIAN INFORMATION (REQUIRED)	
Patient Last Name:	Patient First Name:	Office / Practice:	
Street:		Ordering Physician:	
City:	State:	Zip:	Street:
Date of Birth:	Gender:	Phone:	City:
DIAGNOSTIC CODE (ICD-10):		State:	
EGFR SENSITIZING MUTATION STATUS*: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		Zip:	
BILLING INFORMATION (REQUIRED—CHECK ONLY ONE BOX)		Office/Practice Primary Contact:	
<input type="checkbox"/> Patient insurance information is ATTACHED (<i>i.e., Patient FaceSheet</i>) <input type="checkbox"/> Patient does not have insurance - please call 1-866-432-5930 to have a financial assistance application faxed to physician		Phone: _____ Fax: _____	
		CC Physician/Practice: _____ Fax: _____	
		Test Result Delivery: <input type="checkbox"/> Encrypted Email _____ <input type="checkbox"/> Fax _____ <small>By checking either box, you are authorizing the electronic delivery of test results by Biodesix in accordance with the Health Insurance Portability and Accountability Act and the rules reflected in the HITECH Act.</small>	
TEST MENU (REQUIRED)		PRACTICE INFORMATION (REQUIRED)	
<p>Select the box next to Biodesix Lung Reflex to order the full test offering, or check any of the individual options below to order tests individually</p> <input type="checkbox"/> Biodesix Lung REFLEX™ tests <i>GeneStrat genomic test (all mutations) will reflex to VeriStrat proteomic test</i>		<input type="checkbox"/> Independent Physician or Clinic <input type="checkbox"/> Hospital or Hospital-associated Office	
<p>A LA CARTE ORDERING OPTIONS:</p> <input type="checkbox"/> VeriStrat® testing only <i>For EGFR sensitizing negative or unknown</i>		BLOOD DRAW INSTRUCTIONS	
<input type="checkbox"/> GeneStrat® testing only (all mutations) OR check individual markers to test specific mutations: <input type="checkbox"/> EGFR sensitizing (del19, L858R) <input type="checkbox"/> EGFR resistance (T790M) <input type="checkbox"/> ALK <input type="checkbox"/> ROS1 <input type="checkbox"/> RET <input type="checkbox"/> KRAS <input type="checkbox"/> BRAF		<input type="checkbox"/> In Office <input type="checkbox"/> Hospital <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Independent Lab (enter name): <input type="checkbox"/> Coordinate Home Phlebotomy * <i>* Please fax this form to 1-866-432-3338</i>	
<input type="checkbox"/> EGFR Resistance (T790M) testing only		<input type="checkbox"/> Independent Phlebotomist (enter name): _____	
<small>To order test kits online or for more information on available tests, refer to biodesix.com</small>			
PATIENT CHARACTERISTICS			
Performance Status: _____ Histology: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Squamous <input type="checkbox"/> Other: _____			
AUTHORIZATION AND CERTIFICATION OF MEDICAL NECESSITY (REQUIRED)			
<small>Your signature constitutes a certification of medical necessity and intent to consider and use the results of the test(s) ordered. All of the information on this form is true and correct. You have obtained patient consent and authorize Biodesix to use and release the results and patient information for reimbursement purposes and as may be appropriate for additional clinical testing services.</small>			
Signature of treating physician or authorized representative		Date	