



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):	EGFR SENSITIZING MUTATION STATUS: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
BILLING INFORMATION (REQUIRED—CHECK ONLY ONE BOX)		Office/Practice Primary Contact: Phone: _____ Fax: _____	
<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		CC Physician/Practice: _____ Fax: _____	
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 <input type="checkbox"/> GeneStrat® testing only (all mutations) <i>OR check individual markers to test specific mutations:</i> <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		BLOOD DRAW INSTRUCTIONS (REQUIRED)	
<input type="checkbox"/> EGFR Resistance (T790M) testing only		<input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> In Office <input type="checkbox"/> Hospital (inpatient) <input type="checkbox"/> Hospital (outpatient) <input type="checkbox"/> Independent Lab (enter name): <input type="checkbox"/> Coordinate Home Phlebotomy * <i>* Please fax this form to 1-866-432-3338</i>	
<p><i>To order test kits online or for more information on available tests, refer to biodesix.com</i></p>			
PATIENT CHARACTERISTICS			
Performance Status: _____ Histology: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Squamous <input type="checkbox"/> Other: _____			
AUTHORIZATION AND CERTIFICATION OF MEDICAL NECESSITY (REQUIRED)			
<p>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.</p>			
<p>Signature of treating physician or authorized representative. _____</p>		<p>Date _____</p>	
<p>Medicare Signature Requirements for providers define a valid signature as "handwritten or electronic." Please provide a wet ink or electronic signature on this form. If you are unable to do so, please contact Biodesix Customer Care at 1-866-432-5930.</p>			