Onco-Decision Diagnostics, LLC
11142 Hopes Creek Rd.
College Station, TX 77845
Phone: 979.704.0245
Fax: 979.704.0246

PATIENT INFORMATION

LAST NAME	FIRST	MI.	DOB: Mo / Day / Year	GENDER
			/ /	☐ Male ☐ Female
ADDRESS			CELL #	HOME #
CITY	STATE	ZIP	EMAIL	Social Security # - -

BILLING OPTIONS

☐ Bill Client/Referring Institution

Bill To: Attn: Address City State Zip

☐ Bill Credit Card

Credit Card Number Expiration Date: Mo / Day / Year CCV Billing Address ☐ Same as above City State Zip

☐ Bill Insurance (Please send front and back copy of Insurance Card. We currently do not take Medicare, Tricare, or any other Government Insurance.)

POLICY HOLDER'S NAME DOB: Mo / Day / Year INSURANCE COMPANY POLICY/CONTRACT # GROUP #

For payment of completed services, I transfer and assign any benefits of insurance to Onco-Decision Diagnostics, LLC (ODDx) and authorize claims to be submitted on my behalf directly to my medical insurance. I authorize ODDx to release to Medicare and any and all insurance carrier(s) of which I am associated with, any medical information to resolve claim for payment. I agree that this authorization will cover all medical services rendered by ODDx to me until such authorization is revoked in writing by me.

I understand and acknowledge that I will forward any payment that I receive from my insurance carrier/health plan for services rendered by ODDx. In the event that insurance does not pay, I acknowledge that I may be responsible to pay any deductible, co-pays, or co-insurance.

I consent and understand that ODDx may keep my de-identified samples for new method validation or other research and development. I may request disposal of my blood sample by submitting a written request to Onco-Decision Diagnostics, LLC, Attn: Lab Manager, 11142 Hopes Creek Rd., College Station, TX 77845 within 90 days of test completion.

REQUIRED Patient Signature: **X** _____ Date _____/_____/_____

TEST MENU

CellSearch Tests for Circulating Tumor Cells

- ☐ For Breast Cancer
- ☐ For Prostate Cancer
- ☐ For Colorectal Cancer

CPT CODES

Test Codes

86152 - Cell Enumeration using Immunologic Selection and Identification in Fluid Specimen

86153 – Physician Interpretation & Report

DIAGNOSIS CODES

1_____ 2_____ 3_____

4_____ 5_____ 6_____

7_____ 8_____ 9_____

10_____ 11_____ 12_____

REFERRING PHYSICIAN TO BE CONTACTED WITH RESULTS AND/OR QUESTIONS

Referring Institution	Referring Physician	Email	Phone:
Address	City	State Zip	Fax:

Referring Physician Signature: **Date:**

X _____ _____

By signing, I acknowledge that these tests are medically necessary for my patient and I authorize ODDx to perform the test(s) indicated on this requisition form. Provider responsible for documenting informed consent prior to ordering the test.

SPECIMEN INFORMATION

Date Collected

_____/_____/_____ _____:_____ ☐ AM ☐ PM

Number of Tubes: Notes:

_____ _____

_____

Collector/Phlebotomist: Signature:

_____ _____

SPECIMEN RECEIPT (Lab Use Only)

Date Received Time Received

_____/_____/_____ _____:_____ ☐ AM ☐ PM

Condition of Specimen: ☐ Pass ☐ Fail Notes:

_____

ID 1/2: _____

Received by:

_____