

For Pathology:  
R \_\_\_\_\_

Please order **Oncotype DX™** for \_\_\_\_\_

PATIENT NAME (FIRST) PATIENT NAME (LAST)

FAX TO PATHOLOGY \_\_\_\_\_

PLEASE DO NOT SEND THIS FORM DIRECTLY TO GENOMIC HEALTH. THIS FORM MUST BE ACCOMPANIED BY AN ONCOTYPE DX REQUISITION FORM AND MUST CONTAIN THE REQUISITION BARCODE NUMBER.

Instructions for Pathology: On the Oncotype DX Requisition Form, please complete the patient name and date of birth as well as all other fields not on this form (including Pathology Information). Place a barcode label from the requisition form or write the barcode number in the top right corner of this form. Submit both the Requisition Form and this form with the Oncotype DX specimen.

I. ACCOUNT INFORMATION			II. PATIENT INFORMATION		
ACCOUNT NAME	ADDRESS		NAME OF PATIENT: Last name	First name	MI
ADDRESS	ADDRESS		DOB	Sex: <input type="checkbox"/> Female	<input type="checkbox"/> Male
CITY	STATE	ZIP	ADDRESS	CITY	STATE
PHONE #	PHONE #		MEDICAL RECORD/PATIENT #	SSN	

III. BILLING INFORMATION		
SUBMITTING DIAGNOSIS	<b>MEDICARE ONLY:</b> <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Non-Hospital Patient (> 24 Hours) <input type="checkbox"/> SIGNED ABN ATTACHED IF REQUIRED	PRIMARY INSURANCE NAME
ICD-9 CODE		PRIMARY INSURANCE ADDRESS
<b>METHOD OF PAYMENT</b> <input type="checkbox"/> BILL PRIVATE INSURANCE <input type="checkbox"/> BILL MEDICARE <input type="checkbox"/> BILL MEDICAID	<input type="checkbox"/> COPY OF FRONT AND BACK OF PATIENT INSURANCE CARD ATTACHED <i>If not, fill out all information below and to right.</i>	CITY
<input type="checkbox"/> BILL ACCOUNT <i>No further billing information required.</i>		STATE
<input type="checkbox"/> PATIENT SELF-PAY: <i>Check (US only), certified funds, money order, or credit card information required for processing. No further billing information required.</i>	RELATIONSHIP TO INSURED: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____	PRIMARY INSURANCE PHONE #
Name on Credit Card _____ CC# _____ Expiration Date ____/____/____	MEMBER ID # _____ GROUP # _____ NAME OF INSURED: Last name First name MI DOB Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	REFERRAL/AUTHORIZATION #
		SECONDARY INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If you would like us to bill secondary insurance, you must attach a copy of the front and back of the secondary insurance card.</i>

IV. REQUIRED SIGNATURE	V. ORDER INFORMATION			
SIGNATURE OF ORDERING PHYSICIAN  X DATE  PRINT NAME	TREATING PHYSICIAN	UPIN	ADDITIONAL PHYSICIAN (optional)	UPIN
	PHONE #	FAX #	PHONE #	FAX #
	SPECIALTY: <input type="checkbox"/> Surgery <input type="checkbox"/> Oncology <input type="checkbox"/> Other _____		SPECIALTY: <input type="checkbox"/> Surgery <input type="checkbox"/> Oncology <input type="checkbox"/> Other _____	
	OVERNIGHT MAIL ADDRESS: <input type="checkbox"/> Same as account		OVERNIGHT MAIL ADDRESS: <input type="checkbox"/> Same as account	
	CITY	STATE	ZIP	CITY
	REPORT DELIVERY PREFERENCES: <input type="checkbox"/> Overnight Mail <input type="checkbox"/> Fax <input type="checkbox"/> Online Secure Access		REPORT DELIVERY PREFERENCES: <input type="checkbox"/> Overnight Mail <input type="checkbox"/> Fax <input type="checkbox"/> Online Secure Access	
	E-MAIL ADDRESS (for report notification)		E-MAIL ADDRESS (for report notification)	

Comments: