

Cologuard® and SimpleScreen™ CRC
Order requisition form

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Test selection: <i>Select one</i>			
☐ Cologuard: Stool-based DNA test with hemoglobin immunoassay component		☐ SimpleScreen CRC: Blood-based DNA test	
☐ Blood draw managed by: ☐ Exact Sciences ☐ Ordering provider			
Provider and order information: <i>Typed responses recommended — find editable and printable versions at www.exactsciences.com/science/labs</i>			
Healthcare organization name:			
Provider full name:		NPI: _____	
Provider address			
City:	State:		ZIP:
Phone number:		Secure fax number:	
ICD-10 code: ☐ Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon (Z12.11) and rectum (Z12.12)) ☐ Others: _____			
Patient information			
First name:		Last name:	
Patient ID/MRN:	DOB (MM/DD/YYYY): ____/____/____	Sex: ☐ Male ☐ Female	
Email:		Language preference: ☐ English ☐ Spanish ☐ Other	
Phone number (required): ☐ Home ☐ Mobile ☐ Work			
Shipping address:		PO Box/Apt #:	
City:	State:		ZIP:
Billing address: ☐ Same as shipping address			
City:	State:		ZIP:
Patient insurance and billing information: <i>Attach a copy of both sides of primary and/or secondary insurance cards</i>			
Type: ☐ Private ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Tricare ☐ Self-pay			
☐ Blood collected for hospital inpatient		Policyholder name:	
Policyholder DOB (MM/DD/YYYY): ____/____/____		Relationship to policyholder: ☐ Self ☐ Spouse ☐ Other	
Primary insurance carrier:			
Claims submission address:			
Subscriber ID/policy number:		Group number:	
Plan:		Prior authorization code (if available):	
Certification and outreach: By submitting this order, I certify that I am a licensed healthcare provider authorized to order this test. This test is medically necessary and the patient is eligible for this test. I will maintain the privacy of test results and related information as required by HIPAA, and I will use the results in the management of the patient. I have educated the patient and have received the patient's informed consent to proceed with testing and to submit all necessary information to insurance for payment. I authorize Exact Sciences Laboratories to obtain reimbursement for the test and to direct contact and collect additional samples from the patient as appropriate. I understand that the diagnosis codes listed on this form are for convenience and are not intended to influence an ordering provider's medical judgment. Only diagnosis codes that best describe the reason for performing the test are reported. I affirm that this patient consents to receiving outreach at the phone number, email, and address provided on this form. They can update communication preferences by calling +1 844-870-8870 and visit www.exactsciences.com/privacy-trust to find Exact Sciences' privacy policy, HIPAA notice, and SMS terms.			
Ordering provider signature: _____		Order date (MM/DD/YYYY): ____/____/____	