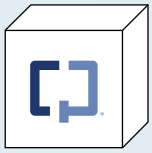
ALL DONE!

HERE'S WHAT TO DO WITH YOUR CUSTOMIZED ORDER FORM.

1. Print or Save this PDF file
2. Take the printed copy to your healthcare provider or email the PDF file to them
3. Talk to your healthcare provider about whether or not Cologuard is right for you
4. If your healthcare provider decides Cologuard is right for you, ask them to complete the order form on page 2



HEALTHCARE PROVIDERS

If you determine Cologuard is right for your patient, please verify the information entered by the patient below before filling out the rest of the form and faxing it to the number provided.

To learn more or contact us, visit **CologuardTest.com/HCP** or call us any time at **1-844-870-8870**.

DISCLAIMER: Exact Sciences only provides an editable order form in order to attempt to optimize Exact Sciences Lab's order processing and patient care efforts by trying to allow for better accuracy and legibility of the completed information.

COLOGUARD® ORDER REQUISITION FORM

EXACT SCIENCES LABORATORIES, LLC
145 E. Badger Rd, Ste 100, Madison, WI 53713
P: 844-870-8879 | www.exactlabs.com
Fax completed form to 844-870-8875

Provider & Order Information

Recommended: type all Provider information.
Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization: _____

Provider Name: _____

NPI #: | | | | | | | | | | |

(or DEA # if NPI is not available)

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

*To receive results for this order, please provide **secure** FAX number only

TEST INFORMATION

Test Name: Cologuard

Test Description: Stool-based DNA test with hemoglobin immunoassay component

ICD-10 Code:

☐ Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

☐ Other(s) _____

We will not ship a collection kit to the patient if ICD-10 coding is missing. The above code is listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.

Certification

I am a licensed medical professional authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect a second sample from the patient as appropriate.

_____

Ordering Provider Signature **Date of Order**

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan & furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights & benefits under my insurance plans to Exact & authorize Exact to appeal & contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider.

Patient Signature: _____ **Date:** _____

Patient Information

Attach a copy of the front & back of primary and/or secondary insurance cards.

PATIENT INFORMATION: *Recommended – also attach a patient demographic sheet*

Patient ID/MRN: _____

First Name: _____ Last Name: _____

DOB* (mm/dd/yyyy): ___/___/_____ Sex: ☐ Male ☐ Female

*Medicare/Med Advantage coverage for patients between ages 50-85

Phone Number *(required)*: _____

☐ Home ☐ Mobile ☐ Work

Email address: _____

Language Preference *(optional)*: _____

PATIENT ADDRESS

Shipping Address: _____

_____

City, State, Zip: _____

Billing Address: _____

☑ *Same as Shipping*

_____

City, State, Zip: _____

Patient Insurance/Billing Information

Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Policyholder Name: _____ **Policyholder DOB:** ___/___/_____ **Relationship to patient:** ☐ Self ☐ Spouse ☐ Other

Type: ☐ Insurance ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Tricare ☐ Self-Pay

Insurance Carrier/Program: _____ **Customer Service # on Insurance Card:** _____

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ **Group Number:** _____ **Plan:** _____

Fax completed form to 844-870-8875

For Laboratory Use Only
Sample Collected: __/__/_____
Sample Received: __/__/_____