

**Provider & Order Information**

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

**PROVIDER INFORMATION**

Healthcare Organization Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

NPI #: 

--	--	--	--	--	--	--	--	--	--

Location Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Secure Fax Number\*: \_\_\_\_\_

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

**ORDER INFORMATION**

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

**ICD-10 Code:**

- Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])  
 Other(s) \_\_\_\_\_

**Certification**

I am a licensed healthcare provider 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 additional samples from the patient as appropriate.

\_\_\_\_\_  
**Ordering Provider Signature**

\_\_\_\_\_  
**Date of Order**

**Patient Demographics**

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

Patient ID/MRN: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB (mm/dd/yyyy): \_\_\_\_\_ Sex:  Male  Female

Shipping Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number (required): \_\_\_\_\_  
 Home  Mobile  Work

Language Preference (optional): \_\_\_\_\_

Billing Address: \_\_\_\_\_  
 Same as Shipping

City, State, Zip: \_\_\_\_\_

**PATIENT ETHNICITY AND RACE**

*The completion of this section is optional.*

Is your patient of Hispanic or Latino origin or descent?  Yes  No

Please mark one or more to indicate your patient's race:

- White  Black or African-American  Asian  Native Hawaiian or other Pacific Islander  American Indian or Alaska Native

**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.*

Does patient wish Exact Sciences to bill their insurance?  Yes (complete below)  No (patient will self-pay)

Policyholder Name: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_ Relationship to patient:  Self  Spouse  Other

Primary Insurance Carrier: \_\_\_\_\_ Type:  Private  Medicare  Medicare Advantage  Medicaid  Tricare

Claims Submission Address: \_\_\_\_\_

Subscriber ID/Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Plan: \_\_\_\_\_

Prior-Authorization Code (if available): \_\_\_\_\_

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

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan and furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to Exact and authorize Exact to appeal and 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. I further understand that if I am a Medicaid enrollee in a state where Exact is enrolled as a Medicaid provider, Exact will accept as payment in full the amounts paid by the Medicaid program, plus any deductible, coinsurance or copayment which may be required by the Medicaid program to be paid by me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax completed form to 844-870-8875**

**For Lab Use Only**

Sample Collected: \_\_\_/\_\_\_/\_\_\_ Sample Received: \_\_\_/\_\_\_/\_\_\_