

InVisionFirst[™] Test Order Form

LUNG

For Inivata
Use Only

(844) 464-8282
(919) 371-5143
client.services@inivata.com

FOR COLLECTION SITE USE

Blood Draw Date:

PATIENT INFORMATION

Patient Name (Last, First MI)

Male Female

Date of Birth (mm/dd/yyyy)

Medical Record Number/Patient ID

Address City State ZIP

Area Code Phone Number

TEST & INTENDED USE

Test: Tissue Type: Adenocarcinoma
Squamous Cell
Other

Submitting Diagnosis NSCLC Other

NSCLC Stage Stage IIIB Stage IIIC Stage IV Other

ICD-10 Code

Testing History: *(Please include pathology report with order)*

At Diagnosis

Patient has NOT had Comprehensive Genomic Profile (EGFR, BRAF, ALK, and ROS1) and tissue testing is not feasible or invasive biopsy is medically contraindicated (Quantity Not Sufficient)

At Progression

Patient has NOT had Comprehensive Genomic Profile (EGFR, BRAF, ALK, and ROS1) and comprehensive genomic profiling with tissue is infeasible

Patient progressing on tyrosine kinase inhibitors (TKIs)

Targeted Therapy Prescribed

BILLING INFORMATION

Billing Type

- Private Insurance
- Patient Pay (Inivata will contact Office)
- Bill Hospital (Contract must be in place)
- Medicaid
- Medicare

Hospital Status at Time of Specimen Collection (Medicare Only)

Inpatient No Yes

If "Yes," Discharge Date

INSURANCE INFORMATION

Primary Insurance

Insurance Name Insurance Member ID

Insurance Policy Holder Name Prior Authorization Number

Secondary Insurance

Insurance Name Insurance Member ID

Insurance Policy Holder Name Prior Authorization Number

ORDERING PHYSICIAN & ATTESTATION

Ordering Physician

Hospital/Practice Name NPI #

Address City State ZIP

Physician Administrative Contact Name

Email Address

Phone Number:

Area Code Phone Number

Fax Number:

Area Code Fax Number

Ordering Physician Attestation:

My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit Inivata to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (d) release the test results to the patient's insurance as needed for reimbursement purposes.

Ordering Physician Signature Date

Print Ordering Physician Name