CLIENT

ACCOUNT NO.

DIAGNOSTIC LABORATORY SERVICES, INC.

Great Science. Great People.

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TOLL FREE (1-800) 655-4176
99-859 IWAIWA STREET, AIEA, HAWAII 96701

BILL TO ☐ INSURANCE / PATIENT ☐ PHYSICIAN / INSTITUTION

PATIENT ID

ORDERING PROVIDER	PATIENT NAME (LAST)	FIRST	M.I.	SEX ☐M ☐F ☐X	DOB (MM/DD/YY)
	ADDRESS				
SEND DUPL. REPORT TO	CITY	STATE	ZIPCODE	PRIMARY TELEPHONE	SECONDARY

Prior Authorization #	PRIMARY INS. INSURER	MEMBERSHIP NO. / COV / GRP	SUBSCRIBER NAME
Prior Authorization #	SECONDARY INS. INSURER	MEMBERSHIP NO. / COV / GRP	SUBSCRIBER NAME

Self-Pay

Patient status at time of collection ☐ Office (non-hospital) ☐ Outpatient ☐ Not yet discharged

OR ☐ Inpatient *(discharge date MM/DD/YYYY):* / / *(required for all Medicare patients)*

Current Diagnosis/Patient History

Diagnosis: ☐ NSCLC ☐ Melanoma ☐ Colorectal Carcinoma ☐ Ovarian ☐ Breast ☐ Pancreatic ☐ GIST ☐ CNS

Other _____

Disease Status *(select all that apply):* ☐ Metastatic ☐ Recurrent ☐ Refractory ☐ Relapse ☐ Other _____

Stage _____ ICD Codes *(only codes beginning C or D accepted)* _____ ECOG Performance Status _____

Transplant Information _____ Target Therapies _____ Immunotherapies _____

Organ Function: ☐ Good ☐ Fair ☐ Poor ☐ Other _____

Test Selection | *Select one*

Genomic test	*Description*	*Accepted Specimen Type*
◯ **NGS Oncology Tumor Profile (72060)**	Companion diagnostic for solid tumors	FFPE Tissue
◯ **NGS Melanoma Tumor Profile (72070)**	Companion diagnostic for malignant melanoma	FFPE Tissue

Specimen Retrieval

Surgical Pathology Accession Number _____ Pathology Lab Name _____

Date of Collection (MM/DD/YYYY) _____ Specimen Site _____

Certificate of Medical Necessity/Consent/Test Authorization and Physician Signature

My signature constitutes a Certificate of Medical Necessity, certifies that this test information will inform the patient's ongoing treatment plan, and certifies that I am the patient's treating physician. 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 Diagnostic Laboratory Services, Inc. to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposed, (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 third-party payer as needed for reimbursement purposes.

My signature also authorizes Diagnostic Laboratory Services, Inc. to select the most appropriate test based on requisition/pathology information.

Treating Physician Signature _____ Printed Name *(Full legal name)* _____ Date *(MM/DD/YYYY)* _____