

## 1 | SUBMITTING PHYSICIAN ACCOUNT INFORMATION

Physician Name: \_\_\_\_\_  
 Institution: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 NPI #: \_\_\_\_\_  
 Account #: \_\_\_\_\_  
 Results delivery:  fax  email  mail

## 2 | PATIENT INFORMATION

Patient's Face Sheet attached to the Test Requisition

Name: \_\_\_\_\_  
 Last First Middle Initial  
 DOB: \_\_\_\_\_ Sex:  MALE  FEMALE  
 (MM/DD/YYYY)  
 Street Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ MR # or SSN: \_\_\_\_\_

## 3 | ESTABLISHED ICD-9 CODES (Do not circle, write in section 4)

193 Malignant Neoplasm of thyroid gland 241.0 Nontoxic uninodular goiter  
 226 Benign Neoplasm of thyroid gland 241.1 Nontoxic multinodular goiter  
 237.4 Thyroid neoplasm, uncertain behavior 246.2 Cyst of thyroid

## 4 | FNA SPECIMEN & DIAGNOSIS INFORMATION

Private Practice patient  In-patient  Out-patient  
 Date of FNA procedure (sample collection): \_\_\_\_\_  
 Date sent to Asuragen CLIA Laboratory: \_\_\_\_\_  
 Suspicious ultrasound findings:  
 Hypoechoic  Intranodular vascular pattern  
 Irregular border  Other, please specify \_\_\_\_\_  
 Microcalcifications \_\_\_\_\_  
 ICD9 Codes: \_\_\_\_\_  
 Clinical history: \_\_\_\_\_  
 Size of nodule/s (A and B, if applicable): \_\_\_\_\_  
 Cytology diagnosis:  
 Benign\*  Suspicious for Cancer  
 Atypical/FLUS  Malignant  
 Suspicious for Neoplasm (Hurthle or Follicular)  Insufficient for Diagnosis

\*Additional medical records necessary

## 8 | ORDERING PHYSICIAN'S SIGNATURE

I hereby certify that the request for the above mutation and/or translocation test/s for which reimbursement from Medicare, or third party payors, will be sought by Asuragen is reasonable and medically necessary for the diagnosis, care and treatment of this patient's condition. I also authorize Asuragen to send on my behalf this patient's test results to the patient's third party payor.

Signature	Print name	Order date
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## 5 | SPECIMEN LABELS (Removable)

Please indicate the location of the nodule/s biopsied by marking the thyroid image with an "A" or a "B" for the first and second nodule respectively (when applicable). Next, adhere a barcode label ending with "-A" or "-B" to the RNA Retain vial containing the corresponding FNA specimen.



## 6 | TEST MENU

1.  miRInform® Thyroid Panel  
 (BRAF (1), KRAS (7), HRAS (3), NRAS (3), RET/PTC1, RET/PTC3, PAX8/PPARG)

## 7 | BILLING INFORMATION

We do not accept Medicaid. Complete billing information must be provided below.  
 NOTE: If patient is a minor, parent or guardian information is required.

Copy (front and back) of patient's insurance card (s) is attached

Insurance carrier: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group name: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policy holder phone #: \_\_\_\_\_  
 Policy holder DOB: \_\_\_\_\_  
 (MM/DD/YYYY)  
 Relation to patient: \_\_\_\_\_

Bill to:  Insurance  Patient  Medicare  Laboratory Account

SECONDARY INSURANCE: As a courtesy you may also submit secondary insurance information. Please attach a copy (front and back) of your secondary insurance.