



Attn: CLIA Laboratory
 2150 Woodward St., Suite 100
 Austin, TX 78744, USA
 Phone #: (512) 681-5200
 Fax #: (512) 681-5201
 www.asuragen.com
 orders@asuragen.com

TEST REQUISITION FORM

1 | SUBMITTING LABORATORY ACCOUNT INFORMATION

Laboratory Name: _____
 Street Address: _____
 City, State, ZIP, Country: _____
 Phone #: _____
 Fax #: _____
 Physician/ NPI #: _____
 Account #: _____
 Results delivery: mail fax FTP

or

2 | SUBMITTING PHYSICIAN ACCOUNT INFORMATION

Physician/ NPI #: _____
 Street Address: _____
 City, State, ZIP, Country: _____
 Phone #: _____
 Fax #: _____
 Additional Physician: _____
 Account #: _____
 Results delivery: mail fax FTP

3 | PATIENT INFORMATION

Patient's Face Sheet attached to the Test Requisition

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

5 | TEST MENU

1. **KRAS (Codon 12 and 13) 7 Mutations only**
 If result negative, reflex to BRAF (Codon 600) Mutation Test
2. **BRAF (Codon 600) Mutation only**
3. **KRAS (Codon 12 and 13) 12 Mutations and BRAF (Codon 600)**

6 | SPECIMEN TYPE - MATERIALS SHIPPED

Date of surgery (sample collection): _____
 Date sent to Asuragen CLIA Laboratory: _____
 Specimen block ID: _____
 Histology slides: 1 H&E slide
 # unstained slides: _____ (minimum 1 x 10µm tissue slide, tissue surface area ≥1cm²)
 # H&E slides: _____ # other (specify): _____
 FFPE block # FFPE specimens: _____ FFPE block to be returned to the submitter
(additional charges apply)
 Enrichment to ≥40% required (additional charges apply)
 Shipment notification sent to Asuragen
(see Specimen Shipping and Handling Requirements)

8 | ORDERING PHYSICIAN'S SIGNATURE

I hereby certify that the request for the KRAS and BRAF Mutation Tests from 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 in connection with an appeal of a reimbursement denial or other reimbursement matter, but only where Asuragen has previously attempted to obtain the reimbursement without the release of such results. Additionally, I certify that this patient has been notified that additional testing via Asuragen's CLIA Laboratory process has been requested.

Signature	Print name	Order date
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4 | BILLING INFORMATION

As a courtesy we will bill your insurance. We do not accept Medicaid. Please attach a copy (front and back) of insurance card(s); complete billing information must be provided below.

NOTE: If patient is a minor, parent or guardian information is required.

Patient's Face Sheet attached to the Test Requisition

Insurance carrier: _____
 Policy #: _____
 Group name: _____
 Group #: _____
 Street Address: _____
 City, State, ZIP, Country: _____
 Phone #: _____
 Fax #: _____
 Policy holder phone #: _____
 Policy holder DOB: _____
(DD/MM/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. You must also provide the following information: secondary insurance carrier, policy #, group name and group #, billing address and phone #, policy holder name, ID #, DOB, relation to patient and phone #.

7 | DIAGNOSIS

Clinical diagnosis: _____
 ICD9 Codes: _____
 Pertinent patient clinical history: _____

9 | LABORATORY USE ONLY

Specimen Received :	DATE : _____	TIME: _____	Box opened by: _____
Primary Data Entry:	DATE : _____	TIME: _____	Initials: _____
Data Entry Verified by:	DATE : _____	TIME: _____	Initials: _____