Quest National Account #: 97513526

ASPiRA LABS® YOUR HEALTH. OUR PASSION. Ova1+

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Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

Collection Date: _____ **Phlebotomist Initials:** _____ ☐ Physician Office ☐ Draw Site ☐ Other

TEST REQUEST FOR OVA1

☑ **VDS-125** [FEMALE SERUM ONLY] Ova1+ OVA1®+ is a reflex test in which OVA1® is performed and then reflexes to OVERA® if the OVA1® result is in the intermediate range.

PHYSICIAN INFORMATION

Physician name(s): _____ NPI#: _____

Name/Account #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Fax copy to: _____

PATIENT INFORMATION

Last name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ DOB (mm/dd/yy): __ __ / __ __ / __ __ __ __

Phone number: _____

Ethnicities (Check all that apply)

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian
☐ Hispanic ☐ Native American ☐ African American
☐ Other:_____

CLINICAL INFORMATION

Menopausal Status: ☐ Pre-Menopausal ☐ Post-Menopausal

Size of mass (longest dimension): _____

Height: _____ Weight: _____ Date of last menstrual period: _____

PATIENT AUTHORIZATION

I authorize ASPiRA LABS Inc. to release medical information related to services provided herein and authorize payment directly to ASPiRA LABS Inc. I agree to assume responsibility for payment of charges that are not covered by my healthcare insurer.

***(Patient signature required for verification of benefits)*

**Patient's Signature: _____

Print Name: _____ Date: _____

PHYSICIAN SIGNATURE

I have provided informed consent for the above ordered test.

Physician's Signature: _____

Print Name: _____ Date: _____

BILLING INFORMATION

Bill the Following (required):

☐ Private Insurance ☐ Medicare* ☐ Patient Self-Pay ☐ Medicaid ☐ Ordering Facility (Client Bill)

* By ordering this test for your medicare patient, your patient has met the requirements for use i.e. has an ovarian mass, has surgery planned and is over 18 years of age.

Insurance Information: Attach a copy of front and back of patient insurance card and complete.

Primary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Secondary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Name of insured: Last: _____ First: _____ DOB: _ _/ _ _/ _ _ _ _

Relationship to insured:

☐ Self ☐ Spouse ☐ Dependent ☐ Other

DIAGNOSIS CODES | ICD-10 Codes (check all that apply):

☐ N83.201 Unspecified ovarian cyst, right side+
☐ N83.202 Unspecified ovarian cyst, left side+
☐ N83.209 Unspecified ovarian cyst, unspecified side+
☐ R19.00 Intra-abdominal and pelvic swelling, mass and lump, unspecified site+
☐ R19.03 Right lower quadrant abdominal swelling, mass and lump+
☐ R19.04 Left lower quadrant abdominal swelling, mass and lump+
☐ R19.05 Periumbilical swelling, mass and lump+
☐ R19.09 Other intra-abdominal pelvic swelling, mass and lump+

Other ICD-10 Codes: _____ _____ _____ _____ _____ _____

+This is provided for informational purposes only and is not a guarantee of coverage. It is the provider's responsibility to determine the appropriate codes.