OmniSeq Test Requisition Form

700 Ellicott Street, Buffalo, NY 14203
Phone: (800) 781-1259

Please complete all required fields*
Fax the completed order form to 888-770-4931 or email to support@omniseq.com

ORDERING PROVIDER INFORMATION

Provider Name/Credentials*	NPI#*	
Hospital/Practice Name*		
Street Address*		
City*	State*	ZIP*
Phone #*	FAX #	
Physician Email*		

PATIENT INFORMATION

Patient Last Name*	Patient First Name*	Patient MI
MRN*	DOB*	Gender*
Street Address*		Apt#
City*	State*	ZIP*
Phone (Home)*	Phone (Work)	

May OmniSeq leave a message on voicemail/answering machine?
☐ YES ☐ NO

CLINICAL INDICATION

Test*: ☐ **OmniSeq Comprehensive** ☐ **OmniSeq Immune Report Card (includes PD-L1 IHC)**

Primary Tumor Site ICD-10*	Secondary Tumor Site ICD-10	Tumor Type*
ICD-10 Code*: ________________	ICD-10 Code: ________________	☐ Lung ☐ Breast ☐ Colon ☐ Melanoma ☐ Kidney ☐ Other: ____________________

Stage*	History or Clinical Information to Support Medical Necessity of Testing
Stage*: ____________________	History/Clinical Information*: ____________________

Reason for Testing*

☐ New Diagnosis ☐ Monitoring/Follow Up ☐ BMT
☐ Recurrent/Relapsed ☐ MRD ☐ Other: ____________________
☐ Remission ☐ Staging

Current Cancer Treatment* (Select all that apply)

☐ Surgery/Resection ☐ Immunotherapy ☐ Clinical Trial
☐ Chemotherapy ☐ Targeted Therapy ☐ Other: ____________________
☐ Radiation ☐ Palliative Care
☐ Observation Only (pending results) Additional Therapy Details: ____________________

SPECIMEN INFORMATION* FFPE Block preferred

Please include a copy of the associated pathology report.

Facility Where Block is Located*	Date of Procedure*	Specimen ID#(s)*	Specimen Source*

BILLING INFORMATION*

Complete billing information is required to begin testing. *Attach copies of front and back of insurance card(s).

Has the patient been discharged from a hospital within the last 14 days?*

☐ No ☐ Currently inpatient ☐ Yes: Date of Discharge: ______________ Institution: ______________________

Additional information regarding Medicare's Date of Service Regulation, 42 C.F.R.§414.510, is available at https://www.omniseq.com/order-test/.

Bill To*	Insurance*	Policy #*	Group #	Insured Name*	Insured DOB*	Relationship to Patient*
☐ Insurance* ☐ Self-Pay ☐ Alternate	Primary					☐ Self ☐ Spouse ☐ Child ☐ Other
	Secondary					☐ Self ☐ Spouse ☐ Child ☐ Other

COPY TO (Send Copy of Report)

Name/credentials*	Deliver By: ☐ Email ☐ Fax ☐ Mail Address/Number*:

PROVIDER SIGNATURE *

Signature*	Date*

NOTICE: This requisition constitutes an order for services by a licensed medical provider. I certify the medical necessity of OmniSeq testing and the intent to use the results in the medical management and treatment decisions for the patient. The patient has agreed to molecular testing and consents to the release of their information as needed specifically for third-party reimbursement.