OncoPrism™-HNSCC Requisition Form CT072404

COFACTOR genomics

Complete and Fax to Cofactor Genomics at **+1-(844)-328-5841**

Clinic Personnel Please Include with FAX to Cofactor Genomics

1- Front and back of the patient's insurance card(s)

2- Physician's order for OncoPrism laboratory testing

OncoPrism™ MULTIDIMENSIONAL PREDICTION

CFG ID # (entered by CFG)

For assistance, visit support.cofactorgenomics.com, email support@cofactorgenomics.com, or call +1 (240) 534-1241.
Additional details and instructions for completing this OncoPrism-HNSCC testing form are in the OncoPrism Collection Kit.

1. Physician Information

Physician Name	NPI
Email	FAX
Institution Name	
Institution Address	
Contact Name	Contact Email
Contact Phone	**Testing Results sent to FAX number provided**

2. Clinical Information

Patient MRN

ICD-10 HNSCC Diagnosis Code(s)

HNSCC disease status (check below)

☐ recurrent ☐ metastatic

Previous treatment for R/M disease (check below all applicable)

☐ none	☐ radiotherapy	☐ taxane	☐ platinum	
☐ immunotherapy	☐ cetuximab	☐ other		
PD-L1 status (CPS)	☐ unknown	☐ 0	☐ 1-19	☐ 20+

3. Specimen Requirements

Non-decalcified Formalin Fixed Paraffin Embedded (FFPE) tissue provided as one of the designs below

a) 2 unstained charged slides (5 microns thick) AND 2 curls (10 microns thick) OR

b) 6 unstained charged slides (5 microns thick) OR

c) Other acceptable format (see test instructions)

Samples collected from bone or liver are not acceptable. Patient must have a recurrent and/or metastatic head and neck squamous cell carcinoma diagnosis.

4. Specimen Information

Pathology Lab Name and Contact

Email	Phone	FAX
Accession #	Biopsy Date	
Anatomical Site of Biopsy	**Testing Results sent to FAX number provided**	

5. Patient Identification Information

Name, First	Middle	Last
Date of Birth	Sex	Phone Number
Street Address		
City, State, Zip Code		

6. Physician Authorization and Signature

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of Cofactor Genomics OncoPrism laboratory testing and informed consent has been obtained, as well as any other consent required by my state in order to perform a genetic test on a specimen. I further certify that the test requested is medically necessary and the results of this test will be used in the medical management of the patient. I agree to provide the necessary patient information and medical records required to support billing or reimbursement to Cofactor Genomics.

Printed Physician Name	Signature	Date

OncoPrism™-HNSCC Requisition Form CT072404

COFACTOR genomics

7. Patient Billing Information

Insurance Type (check all that apply)	☐ Medicaid	☐ Medicare	☐ Private Insurance	☐ Hospital/Institution	☐ Veterans Administration	☐ Self-Pay/ Other

Primary Insurance Name	Policy Start/End Dates
Policy Number	Group Number
Secondary Insurance Name	Policy Start/End Dates
Policy Number	Group Number

Patient Relationship to Insured	☐ Self	☐ Spouse	☐ Child	☐ Other

If not self, please provide the following information below for the main policy holder

Policy Holder's Name	Date of Birth	Phone

8. Patient Assignment of Benefits Statement

I acknowledge that payment for any testing and laboratory services provided by Cofactor Genomics will be provided either directly from myself or through applicable health insurance benefits and/or insurance reimbursement. For the purposes of health insurance utilization, I authorize Cofactor Genomics to legally obtain, use, or perform, at minimum, the following tasks for purposes of payment for services performed:

- To obtain and store relevant medical record and insurance information
- To release medical and insurance information necessary to process claims or appeals
- To file medical claims, appeals, and/or grievances with my health plan(s) as stated on this form
- To file appeals or grievances with an external review committee at a state insurance board, independent review organization, Office of Personnel Management, Department of Labor or equivalent agency
- To file any complaint or excess documentation regarding inaccurate or misleading claims processing, appeal processing or pricing to CMS or their agent regarding any applicable Medicaid or Medicare policy
- To collect payment of any and all medical benefits and insurance proceeds directly from my health plan (including Medicare and Medicaid)
- To negotiate and resolve any insurance-related matter regarding a service provided by Cofactor Genomics directly with my health plan(s).

I acknowledge and agree that I remain responsible for applicable co-payments, deductibles and co-insurance as required by my medical and/or other healthcare benefits plans. If I receive payment of medical and/or other health benefits directly on account of services provided by Cofactor Genomics, I will remit the full payment to Cofactor Genomics.

9. Out-of-Network Disclosure

I understand that Cofactor Genomics' services may be designated as out-of-network services by some insurance plans. As a result, there may be costs associated with these services that are not covered by my insurance plan. I hereby consent for out-of-network services to be provided by Cofactor Genomics, and I am responsible for any out-of-network costs associated with services that are not covered by my insurance plan.

10. Authorization Release

I hereby authorize Cofactor Genomics to:

- Obtain personal and medical information necessary for performing laboratory testing and reimbursement;
- Contact pathology to obtain my FFPE specimen and perform laboratory testing ordered by my physician;
- Release any information necessary to my health benefit plan(s) (or its administrator) regarding my illness and treatments;
- Process and submit insurance claims generated during laboratory processing and medical treatment; and
- Allow a photocopy of my signature to be used to process insurance claims, payment, grievances, or appeals.

This authorization will remain in effect until revoked by me through notification of Cofactor Genomics directly in writing.

11. Patient Informed Consent and Signature

By signing below, you understand and agree to all terms described within the OncoPrism-HNSCC Requisition Form

Printed Patient Name	Signature	Date

☐ Subject to required approvals, Cofactor Genomics may use your remaining de-identified specimen for quality control, research and development purposes. Mark the checkbox if you DO NOT wish to have your FFPE specimen used for such purposes.