

Provider & Order Information Recommended: type all Provider information. Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization Name: Auburn University Montgon

Provider Name: Lindsey T Barton, CRNP

NPI #:

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Location Address: 7461 East Drive, Suite 102

City, State, Zip: Montgomery, AL 36117

Phone Number: (334) 244-3281

Secure Fax Number*: (334) 244-3396

*To receive results for this order, please provide secure FAX number only

ORDER INFORMATION

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

ICD-10 Code:

☒ Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

☐ Other(s) _____

Certification

I am a licensed healthcare provider authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect additional samples from the patient as appropriate.

[Signature]
Ordering Provider Signature

3/7/23
Date of Order

Patient Demographics Attach a copy of the front & back of primary and/or secondary insurance cards.

Patient ID/MRN: 1048

First Name: Leon

Last Name: Higdon

DOB (mm/dd/yyyy):

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Sex: ☒ Male ☐ Female

Email: lhigdon@aum.edu

Phone Number (required): (334) 202-8125

☐ Home ☒ Mobile ☐ Work

☒ By checking this box, I confirm that Patient has consented to receive calls or text messages from Exact Sciences Laboratories concerning general CRC screening updates, reminders to screen again for CRC, and other healthcare and general account information.

NOTE: If this box is **not checked**, Exact Sciences Laboratories **will still** be able to provide reminders / notifications to Patient via phone call or text message about their current Cologuard order or test results. If Patient wishes to receive no communications, they may contact 1-844-870-8870 to update their preferences.

Language Preference:

☒ English ☐ Spanish ☐ Other

Shipping Address: 80 BRIGHT SPOT ST.

PO Box / Apt #: _____

City, State, Zip: Pike Road, AL 36064

PATIENT ETHNICITY AND RACE The completion of this section is optional.

Is your patient of Hispanic or Latino origin or descent? ☐ Yes ☐ No

Please mark one or more to indicate your patient's race:

☒ White ☐ Black or African-American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native

Patient Insurance/Billing Information Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Does patient wish Exact Sciences to bill their insurance? ☐ Yes (complete below) ☐ No (patient will self-pay)

Policyholder Name: Leon Higdon Policyholder DOB (mm/dd/yyyy):

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1	9	6	6
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Relationship to patient: ☒ Self ☐ Spouse ☐ Other

Primary Insurance Carrier: BCBS Type: ☒ Private ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Tricare

Claims Submission Address: 450 RIVERCHASE PKWY EAST Birmingham, AL 35244

Subscriber ID/Policy Number: QAU830043425 Group Number: 37655 Plan: _____

Prior-Authorization Code (if available): _____

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

Signature not required for order to be processed

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan and furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to Exact and authorize Exact to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider. I further understand that if I am a Medicaid enrollee in a state where Exact is enrolled as a Medicaid provider, Exact will accept as payment in full the amounts paid by the Medicaid program, plus any deductible coinsurance amount, which may be required by the Medicaid program to be paid by me.

Patient Signature: _____

Date: _____

Fax completed form to 844-870-8875

For Lab Use Only

Sample Collected: / / Sample Received: / /