

* * * Communication Result Report (Aug. 2. 2023 5:43PM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Aug. 2. 2023 5:36PM

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
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Reason for error

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E. 3) No answer
E. 5) Exceeded max. E-mail size

E. 2) Busy
E. 4) No facsimile connection
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P.O Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Cologuard Order

To: Exact Science Laboratories

From: WHS

Fax: 844-870-8875

Pages: 3

Phone: 844-870-8870

Date: 8/2/23

Re: Cologuard order form

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

With appointment details

Comments:

Important: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

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

PROVIDER INFORMATION

Healthcare Organization Name: Auburn University Montgomery

Provider Name: Lindsey Barton, CRNP

NPI #:

1	2	1	5	2	8	5	8	7	9
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Location Address: 7461 East Dr, Suite 102

City, State, Zip: Montgomery, AL 36117

Phone Number: (334) 244-3281

Secure Fax Number*: (334) 244-3281

*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.

Lindsey Barton, CRNP
Ordering Provider Signature

8/2/23
Date of Order

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

Patient ID/MRN: 1145

First Name: Scott

Last Name: Parsons

DOB (mm/dd/yyyy):

0	2
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 /

0	5
---	---

 /

1	9	7	3
---	---	---	---

Sex: ☒ Male ☐ Female

Email: _____

Shipping Address: 7461 East Dr Suite 102

PO Box / Apt #: _____

City, State, Zip: Montgomery, AL 36117

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: Scott Parsons Policyholder DOB (mm/dd/yyyy):

0	2
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 /

0	5
---	---

 /

1	9	7	3
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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 Parkway East

Subscriber ID/Policy Number: QAU820557862 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 or copayment 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: ____/____/____