HelioLiver LDT

Test Requisition Form

Please attach a copy of the front and back of all insurance cards to this TRF.

FOR PHLEBOTOMIST USE	FOR PHLEBOTOMIST USE
Please collect the following specimens for the patient: • Whole Blood: 2 x 10mL PAXgene Blood ccfDNA • Serum: 1 x 8.5mL Serum in Transfer tube COLLECTION DATE: _____ (MM/DD/YYYY)	Affix Collection Kit Barcode Sticker Here

PATIENT

*Required Field

LAST NAME* | FIRST NAME*

DATE OF BIRTH (MM/DD/YYYY)* | GENETIC SEX* ◯ Male ◯ Female ◯ Unknown

MED REC#/PATIENT IDENTIFIER* | PHONE

EMAIL

By opting in below, I give permission for my specimen and clinical information to be used in de-identified research at Helio Genomics and for publication, if appropriate. The patient's name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.helioliverldt.com/privacy. Opting in to research is not required for testing to be conducted.

☐ Opt in to research.

☐ Check if you are a New York state resident and give permission for Helio Genomics to retain any remaining sample longer than 60 days after the completion of testing.

By signing, I give permission to Helio Genomics to perform testing as described, contact me directly as necessary, and use the provided billing instructions to bill the indicated method and release medical information concerning the test to the assigned insurance company

X _____ PATIENT SIGNATURE (REQUIRED FOR BILLING) | _____ DATE (MM/DD/YYYY)

ORDERING PROVIDER

PROVIDER LAST NAME* | PROVIDER FIRST NAME*

NPI* | PHONE*

EMAIL* | RESULTS DELIVERY* ☐ Email ☐ Fax

INSTITUTION/PRACTICE NAME

INSTITUTION ADDRESS

CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PRIMARY CONTACT NAME | PRIMARY CONTACT PHONE

I attest that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing for liver cancer is medically necessary and that test results may impact medical management for the patient.

X _____ ORDERING PROVIDER SIGNATURE (REQUIRED) | _____ DATE (MM/DD/YYYY)

BILLING INFORMATION

Select one billing option and complete all information required in to prevent a delay in test results.

◯ OPTION 1: Patient Self-Pay ◯ OPTION 2: Institutional Billing

INSTITUTION/PAYOR FIRST & LAST NAME* | ATTENTION TO

ADDRESS*

CITY* | STATE/PROVINCE* | POSTAL CODE* | COUNTRY

PHONE* | EMAIL

CREDIT CARD NUMBER* | EXPIRY (MM/YY)* | CVV*

TEST INFORMATION

TEST NAME: HelioLiver | CPT CODE: 0333U

DESCRIPTION: Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of serum of AFP/AFP-L3 and oncoprotein desgammacarboxy-prothrombin (DCP), algorithm reported as normal or abnormal result

ICD-10 Code* (Provider to fill out):

- ☐ K70.30 Alcoholic cirrhosis of liver without ascites
- ☐ K70.31 Alcoholic cirrhosis of liver with ascites
- ☐ K71.7 Toxic liver disease with fibrosis and cirrhosis of liver
- ☐ K74.3 Primary biliary cirrhosis
- ☐ K74.4 Secondary biliary cirrhosis
- ☐ K74.5 Biliary cirrhosis, unspecified
- ☐ K74.60 Unspecified cirrhosis of liver
- ☐ K74.69 Other cirrhosis of liver
- ☐ Other(s) - list in box below

Codes are listed for convenience only.
Ordering medical providers should report the code(s) that best describes the reason for performing the test, regardless if listed.

◯ OPTION 3: Insurance Billing

Please attach front and back of all insurance cards, ABN, medical criteria form.

REFERRAL/PRIOR AUTH

If prior authorization was obtained for this order, please provide the reference number. PA#: _____

PRIMARY INSURANCE ID* | INSURANCE NAME* | STATE* | GROUP* | INSURANCE PHONE #

INSURANCE PLAN* | NAME OF INSURED* | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)*

INSURED'S ADDRESS* | CITY* | STATE* | POSTAL CODE*

SECONDARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

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