

BeScreened™-CRC

Test Requisition Form



Beacon Biomedical Inc.

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Phoenix, AZ 85034 Phone: 480.757.9037
CLIA Number 03D2122615, NPI: 1528561362

PATIENT	Patient Last Name:	First:	MI:	Patient DOB	Sex	SSN
				Not Required		
	Patient Address:			Patient Phone:		
	Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Pacific Islander					
1. Medical History: Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Any family history of colorectal cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No						
BILLING	Payment Preference: <input type="checkbox"/> Self-Pay Credit Card <input type="checkbox"/> Insurance		SELF PAY: A CONTACT PHONE NUMBER IS REQUIRED FOR CREDIT CARD BILLING. BY PROVIDING THIS NUMBER, PATIENT IS AUTHORIZING BEACON TO CALL FOR CREDIT CARD PAYMENT INFORMATION. TELEPHONE NO.: _____			
	Insurance Information: If using insurance, complete the following section and attach a copy of front and back of patient's primary and, if applicable, secondary insurance card. Note: Billing CPT Code for BeScreened-CRC is 0163U and Diagnostic Codes are Z12.9, Z12.11, Z12.12, Z12.13					
	Insured Last Name: _____ First Name: _____ Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse					
	Primary Insurance Carrier: _____ Employer Name: _____ <input type="checkbox"/> Dependent					
	Member ID: _____ Group Name/ID: _____ Carrier Phone Number: _____ Secondary Insurance Carrier (if applicable): _____ Member ID: _____ Group Name/ID: _____ Carrier Phone Number: _____					
PATIENT AUTHORIZATION/ASSIGNMENT (Required): I authorize Beacon Biomedical Inc. to obtain & release relevant medical and other information and to directly bill & submit claims to my insurance providers for laboratory services that Beacon provides to me. I assign insurance benefits to Beacon & acknowledge that charges not covered or exempt by insurance (e.g. no balance billing policies) including applicable co-payments & deductibles, are my responsibility & I agree to pay for such charges. Patient Signature: _____ Print Name: _____ Date: _____						
PHYSICIAN	Medical Reason/Necessity: I affirm this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom or disorder, and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the "Ordering Physician" space below is authorized by law to order the test(s) requested herein. Test is indicated for patients 45-85 years of age, at average risk for colorectal cancer, and who are <u>unable or unwilling</u> to participate in screening using other recommended screening tests, such as fecal-based tests or colonoscopies. Not intended for high-risk patients with family or personal history of cancer, have an inflammatory disease, patients who are pregnant or nursing, that are receiving chemotherapy or radiation, or who are less than 60-days post-surgical procedure.					
	Physician Name (Printed)		Physician Signature		Date	
	Practice Name:		Practice Street Address:		Practice City, State, Zip Code:	
	Practice Phone Number:		Reporting E-Mail Address:		Reporting Fax Number:	
	Preferred Reporting Method <input type="checkbox"/> Fax <input type="checkbox"/> E-Mail		Physician NPI Number:		If ACO/IPA, ID & Phone Number:	
SAMPLE	Date of Specimen Collection:		Time of Collection:	Phlebotomist's Initials:	Collection Site ID:	
	/ /				Physician's Office <input type="checkbox"/> Other <input type="checkbox"/> Site ID: _____ SQL <input type="checkbox"/>	
	Date of Specimen Received		Time Received:	Beacon ASSN #	Sonora Quest Lab Acct/Codes	
/ /				<input type="checkbox"/> Beacon SQL Account No. 1650 <input type="checkbox"/> Pass-through Code 906874		

Blood Draw Patient Service Center Locations

Arizona: At any Sonora Quest Laboratories Patient Service Center Location; visit: <https://www.sonoraquest.com/find-a-location/>
States Other Than Arizona: Contact Beacon Biomedical for coordination of the blood draw at: 1-480-757-9037 (Office). BeScreened™-CRC is available as a CLIA Reference Laboratory Developed Test (LDT) through Beacon Biomedical only (CLIA Lab No. 03D2122615) in all states except CA and NY.