

Please fax form to 615-255-1330

2 International Plaza Drive, Suite 510
Nashville TN 37217
Phone 615-255-8880
www.insightmdx.com

For Insight Molecular Labs Use Only

Accession # _____
Date Received _____ Time Received _____
Technician _____ Total Volume/Number of Slides _____

Ordering Client Information

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone _____
Email (optional) _____
NPI# _____

Results:

- Fax _____
 Phone _____
 Attach a copy of the Pathology Report

ADDITIONAL COMMENTS:

Patient Information - Laboratory

Name _____
Patient/Specimen I.D.# _____
Social Security # (optional) _____
Date of Birth _____ Age _____ Sex M F
Date of Collection _____
Tumor Content % (if known) _____
Primary Tumor Site _____
Specimen Type _____
ICD-10 Diagnosis code (must be provided): _____

SAMPLE RETURN ADDRESS IF NOT ON PATH REPORT:

Address must be provided for sample return. Insight Molecular Labs is not responsible for sample storage beyond 30 days if return is not requested.

Billing Information

- Bill Client Directly Bill Insurance Medicare In-Patient Medicare Out-Patient
Provide information below, or attach copy of insurance card (front and back) and demographic sheet

Insurance Company _____
Subscriber Name _____
Relationship to Insured: Self Spouse Other _____
ID# _____ Group # _____
Insurance Co. Claims Address _____
City _____ State _____ Zip Code _____
Insurance Co. Phone _____

Patient Social Security # (optional) _____
Patient Address _____
City _____ State _____ Zip Code _____
Patient Home Phone _____
Patient Work Phone _____

Indicate Requested Assay

For additional testing needs, please call Client Services. For test sample requirements, please see test fact sheets at <http://www.insightmdx.com/testmenu>.

- 101 Insight TNBCtype by Next Generation Sequencing 720 FGFR Aberration Detection RNA by Real-time PCR (Qualitative)
719 EGFR Mutation Detection DNA by Real-time PCR (Qualitative)

Ordering Physician or Non-Physician Practitioner Certification

Print Name _____ Signature _____ Date _____

- Does this patient give consent to send reports to the submitting lab? Yes No
Does this patient give consent to the use of his/her sample for research? Yes No