Please fax form to 615-255-1330

INSIGHT MOLECULAR LABS

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 %/Neoplastic Cell % (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