WREN Laboratories

688 East Main Street, Branford, CT 06405
Phone: 2032083464; Email: info@wrenlaboratories.com

FORMS MUST BE FULLY COMPLETED.

INCOMPLETE FORMS WILL DELAY SAMPLE PROCESSING AND RESULTS.

Patient Information

Last Name	First	MI	Date of Birth__/__/__	Gender: M ☐ F ☐
Street Address				
City	State	Zip Code	Phone Number	Email
Responsible Party Name		Relationship to Patient: Self ☐	Child ☐	Spouse ☐ Other ☐
Bill To: (Circle One)	Insurance ☐	Patient(Self-Pay) ☐	Client's Office ☐	

Insurance Information: Complete below only if NOT attaching a copy of the front and back of insurance card(s).

Primary Insurance Info:	Secondary Insurance Info:
Subscriber Name	Subscriber Name
Provider Name:	Provider Name:
Provider Address:	Provider Address:
ID#/Group#:	ID#/Group#:

Self Pay: Please fill out credit card information below, or indicate you're billing address if different from above.

Credit Card Type:_____ **Card Number:**_____ **Exp. Date:**_____

Provider & Test Information: You *must* include Provider's Name and Facility.

Ordering Provider's Full Name:_____ **NPI Number:**_____

Provider's Facility:_____ **Phone Number:**_____

Provider's Address:_____

_____ **E-mail:**_____

Diagnosis/Symptoms (Provide ICD10 Code):_____

Note: When ordering tests which Medicare reimbursement will be sought, providers should only order tests that are medically necessary for the diagnosis or treatment of the patient. Medicare generally does not cover routine screening tests or those for research purposes only.

Please indicate below the test(s) to be performed and reason(s) for testing (Tick the Box):

_____***NETest**** (CPT Code: 0007M) (*Whole Blood required for test*)

☐ **Pre- Surgery**
☐ **Post-Surgery (☐ Months)**

_____***Chromogranin A**** (CPT Code: 86316) (*Plasma required for test*)

☐ **Monitoring (Watchful waiting)**
☐ **Monitoring (Somatostatin analog)**
Date of Last SSA Dose _____

☐ **Symptoms (Disease Not Confirmed)**
☐ **Monitoring (Other Therapy)**
☐ **Chemotherapy** ☐ **Target Therapy** ☐ **PRRT**

Blood Collection Date: _____

Physician Signature: By signing below, I have obtained the necessary Patient Authorization for genetic testing as required by State and Federal Law.

Physician Signature:_____Date:_____

Patient Authorization: I authorize release of any medical information necessary to process a claim and request that payment benefits be made to Wren Laboratories.

Patient/Authorized Signature:_____Date:_____