

FORM MUST BE SIGNED BY ALL PARTIES AND RETURNED WITH SAMPLE.

Wren Laboratories Test Request Form

This form must be completed fully. If incomplete, it could delay sample processing and results. Submit form via email (order@wrenlaboratories.com) or fax (+1-260-245-3568).

PLACE LABEL HERE



688 East Main Street, Branford, CT 06405

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Date of Birth (mm/dd/yyyy) _____ Gender Male Female Other

Street _____ City / State / Zip _____

Phone _____ Email _____ Bill to (Select One) Insurance Patient (Self Pay)

Do you have a kit? Yes No If No, Provide Shipping Address _____

PATIENT INSURANCE / BILLING INFORMATION

Please attach a copy of the front and back of the patient's insurance card(s); please also include the face sheet.

Primary Insurance

Policy Holder Name _____

Relationship to Patient Self Child Spouse Other

Primary Insurance Name _____

Claims Submission Address _____

Subscriber ID# / Group # _____

Secondary Insurance

Policy Holder Name _____

Relationship to Patient Self Child Spouse Other

Secondary Insurance Name _____

Claims Submission Address _____

Subscriber ID# / Group # _____

BLOOD DRAW INSTRUCTIONS

In Clinician Office Coordinate Mobile Phlebotomy Alternate Laboratory _____

Initial _____ Date and Time Collected _____

PROVIDER INFORMATION

Ordering Provider's Full Name _____ NPI Number _____

Location Address _____ Phone _____ Fax _____

City / State / Zip _____ Email _____

Account/Practice Name _____ Provider Signature _____ Date _____

Certification: I am a licensed healthcare provider authorized to order Wren Laboratories tests. The test is medically necessary, and the patient is eligible to use the test. All information on this form is true and correct. I have obtained patient consent and authorize Wren Laboratories to use and release the results and patient information for reimbursement purposes and as may be appropriate for additional clinical testing services.

TEST MENU Please indicate below the type of test(s) to be performed & associated ICD-10 Code(s)

Tumor Type _____ NETest2.0 + PPQ NETest2.0 Only PROSTest

Tumor Grade _____ C7A. (e.g. 012) _____ D3A.8 C25.4

KI 67% _____ C61 R97.20 D07.5

ICD 10 CODE: Provide a diagnostic ICD-10 Code for all patients: Ordering provider should report the ICD-10 code(s) that best describes the reason for performing the test. This section is not intended to influence the medical judgement of an ordering provider.

Patient Authorization, Assignment of Benefits (AOB) & Financial Responsibilities.

I authorize Wren Laboratories to bill my insurance/health plan and furnish them with my test order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plan(s) to Wren Laboratories and authorize Wren Laboratories to appeal and contest any reimbursement denial, including any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursement to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider.

Patient/Authorized Signature _____ Date _____