PATHOLOGY PREORDER FORM

Please send specimen with this form, and enclose a completed HERmark® Breast Cancer Assay Test Request Form, which includes the patient specimen label number. Both forms and the label number are essential for proper identification of the specimen.

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FAX TO PATHOLOGY
FAX NUMBER: ( )____________________

Instructions for the Oncologist: On the HERmark Pathology Preorder Form, please complete sections 1, 2, and 3.
Please submit this form to your Pathology Laboratory.

Instructions for the Pathology Laboratory: If you do not have the HERmark Breast Cancer Assay Test Request Form and shipping kit, please call Monogram Biosciences at **1-800-777-0177**. On the HERmark Test Request Form please write the patient name in section 1. Place a specimen label from the Test Request Form or write the specimen label number on this form (Pathology Preorder Form). Please attach this form to the Test Request Form and submit with the specimen to Monogram Biosciences.

1) PATIENT INFORMATION:

Patient Name:____________________ DOB:________
Last First MI

Address:____________________
Street City State ZIP

Telephone:__________ SSN:__________ SEX: ☐ M ☐ F

Patient ID or Medical Record #:__________

Reference/Order/Case #:__________

2) BILLING INFORMATION:

Check one box for billing type and fill out all accompanying information. Attach a copy of the front and back of insurance card(s).

Primary Diagnosis:

____

ICD-9 Code:

____

☐ **Private Insurance**

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Legal Partner

Primary Health Plan Name:__________

Primary Insured ID #:__________

Primary Insurance Telephone:__________

Secondary Health Plan Name:__________

Secondary Insured ID #:__________

☐ **Medicare** > Patient Medicare #:__________

☐ **Medicaid** > Patient Medicaid #:__________

☐ **Client**

☐ **Patient Self-Pay** (Check, money order, or credit card)

Name on Credit Card:__________

Credit Card #:__________

Exp. Date:________ Security Code:________

3) ORDERING INFORMATION:

Facility Name:__________

Address:__________
Street City State ZIP

Telephone:__________ Fax:__________

E-mail Address:__________

ID/License #:__________ NPI #:__________

The HERmark Breast Cancer Assay provides an accurate and quantitative measurement of HER2 protein expression. In my judgment, the HERmark Breast Cancer Assay is medically necessary for this patient.

X____________________ Date:________
Signature of Ordering Physician

____
Print Name

Attach or Write Specimen Label From Test Request Form

SPECIMEN LABEL

INTERNAL USE ONLY:

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