Place specimen label from kit box here
1234567

Test Request Form

Account and Specimen Information

All account and specimen fields are required with each requisition. By submitting this order, you are certifying that this patient or his/her legally authorized representative has provided informed consent for testing and that this consent has been documented in accordance with applicable laws.

eurofins | Transplant Genomics

18000 W. 99th St. Lenexa, KS 66219, Ste. 100
Phone: 844.TRUGRAF
Fax: 888-224-3499
ClientServices@Eurofins-TGI.com

Direct Bill To: ☐ Ordering Institution ☐ Patient or Insurance

ACCOUNT INFORMATION

Account #		
Account Name		
Contact Name	Phone	
Address 1		
Address 2		
City	State	Zip

PATIENT INFORMATION

Name (Last, First)		
Patient MRN #	Address	
Gender	City	
Birthdate	State	Zip Code
Hospital Accession #	Phone	Prior Authorization #

Sent Kit to Patient's Home ☐ No ☐ Yes TGI Mobile Phlebotomist ☐ No ☐ Yes

Parent/Child Transplant ☐ No ☐ Yes

ICD-10 Code (please check one)	Date of most recent transplant (MM/DD/YYYY)

☐ Z48.22 Encounter for aftercare following kidney transplant.
☐ Z94.0 Kidney Transplant Status ☐ Other

ORDERING PHYSICIAN

Name (Last, First)		
Address		
Address 2		Phone
City	State	Zip Code
NPI #		
Authorized Physician Signature (Intent to order or support medical necessity)		Date (MM/DD/YYYY)

STUDY DETAILS

Study Name _____ Study ID _____

TEST REQUESTED

☐ TruGraf® Blood Gene Expression Test
☐ Viracor TRAC® Kidney dd-cfDNA Test

REASON FOR TESTING

☐ Surveillance
☐ For Cause

(Optional) STANDING ORDER Valid for 1 year

Start Date (Order) _____ End Date _____
Check the frequency from first draw:
☐ Every 3 months ☐ PRN ☐ Other (months)

INSURANCE INFORMATION

☐ Attach copy of front and back of insurance card(s)

Name of Primary Insurance _____
Policy/Member # _____
Group # _____
Relationship to Insured: _____
☐ *If you are the patient and policy holder, check this box if the patient information is the same as below.*
Subscriber/Policy Holder Name _____
Subscriber/Policy Holder Gender _____ DOB _____

Name of Secondary Insurance _____
Policy/Member # _____
Group # _____
Relationship to Insured _____
☐ *If you are the patient and policy holder, check this box if the patient information is the same as below.*
Subscriber/Policy Holder Name _____
Subscriber/Policy Holder Gender _____ DOB _____

SPECIMEN COLLECTION INFORMATION

Date Collected (MM/DD/YYYY)	Time Collected		Specimen Draw Facility
_____/_____/_____	_____:_____ ☐ AM ☐ PM	☐ 10 mL whole blood Streck cfDNA BCT for Viracor TRAC®	☐ Quest Facility
		☐ 2 X 2.5 mL whole blood PAXgene Blood RNA for TruGraf®	☐ Patient Home
Phlebotomist Name: _____		Phlebotomist Initials: _____	☐ Hospital/Clinic
			☐ Other

PATIENT BILLING ACKNOWLEDGEMENT

Release of Information, Non-Medicare Insurance Prior Authorization & Appeals: By signing below, I consent to the release of any medical and insurance information necessary for Transplant Genomics, Inc. (TGI) to conduct prior authorizations, billing to insurance and appeals for coverage with primary and secondary insurance carriers. I agree to have information on my insurance coverage communicated to me over the telephone or in person by TGI and/or my clinical care team. At the time my insurance coverage information is communicated to me, I retain the right to decline testing for any reason, including non-coverage or insufficient non-Medicare primary insurance coverage.

Assignment of Benefits: By signing below, I hereby authorize and request that payment of my benefits by my primary insurance company and my secondary insurance (if any) be made directly to TGI for the TruGraf® and/or Viracor TRAC® test furnished to me. I understand that my non-Medicare insurance may only cover a portion of the total bill. If this test is not covered, considered out-of-network due to TGI contract with such non-Medicare primary insurance carrier, or if there is a copayment, coinsurance, or deductible obligation, I accept full financial responsibility for payment obligation.

☐ *I agree to the release of my contact information for the purpose of follow-up contact from Transplant Genomics, Inc.*

Patient Signature _____ Date (MM/DD/YYYY) _____