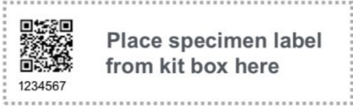

Test Request Form

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.

Transplant Genomics

18000 W. 99th St. Lenexa, KS 66219, Ste. 100
Phone: 844.TRUGRAF
Fax: 888-224-3499
ClientServices@tgi.eurofinsus.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)		
MRN #	Address	
Gender	City	
DOB	State	Zip Code
E-Mail Address		Preferred method of Contact ☐ Phone ☐ Text ☐ E-Mail
Hospital Accession #	Phone	Prior Authorization #

Primary Language ☐ Eng ☐ Span ☐ Other

ICD-10 Code **(please check one)**
☐ 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 #		

STUDY DETAILS (If Applicable)

Study Name	Study ID

TEST REQUESTED (Select One)

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

STANDING ORDER Valid for 1 year (Optional)

Start Date (Order) End Date

Check the frequency from first draw:
☐ Every 3 months ☐ PRN ☐ Other (months)

KIT & DRAW PREFERENCES

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

TRANSPLANT DETAILS

Parent/Child Transplant ☐ No ☐ Yes
Date of most recent transplant (MM/DD/YYYY)

INSURANCE INFORMATION

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

Name of Primary Insurance ____
Policy/Member # ____
Group # ____

Name of Secondary Insurance ____
Policy/Member # ____
Group # ____

SPECIMEN COLLECTION INFORMATION

Date Collected (MM/DD/YYYY) ______/ ______/ ________

Time Collected _____:______ ☐ AM ☐ PM

☐ 10 mL whole blood Streck cfDNA BCT for Viracor TRAC®
☐ 2 X 2.5 mL whole blood PAXgene Blood RNA for TruGraf®

Specimen Draw Facility
☐ Quest Facility
☐ Patient Home
☐ Hospital/Clinic
☐ Other

Phlebotomist Name: ________________________________

Phlebotomist Initials: ______________________

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.

THIS SPACE IS FOR LABORATORY USE

☐ *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) ____________________

AUTHORIZED PHYSICIAN SIGNATURE - INTENT TO ORDER OR SUPPORT MEDICAL NECESSITY

Physician Signature ____ Date (MM/DD/YYYY) ____________________

All TruGraf® and Viracor TRAC® samples tested at Transplant Genomics, Inc., Lenexa, KS

Place specimen label from kit box here

1234567

Test Request Form

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Account Name

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Address 1

Address 2

City | State | Zip

PATIENT INFORMATION

Name (Last, First)

MRN # | Address

Gender | City

DOB | State | Zip Code

E-Mail Address | Preferred method of Contact ☐ Phone ☐ Text ☐ E-Mail

Hospital Accession # | Phone | Prior Authorization #

Primary Language ☐ Eng ☐ Span ☐ Other

ICD-10 Code **(please check one)**
☐ 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 #

STUDY DETAILS (If Applicable)

Study Name | Study ID

TEST REQUESTED (Select One)

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

STANDING ORDER Valid for 1 year (Optional)

Start Date (Order) End Date

Check the frequency from first draw:
☐ Every 3 months ☐ PRN ☐ Other (months)

KIT & DRAW PREFERENCES

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

TRANSPLANT DETAILS

Parent/Child Transplant ☐ No ☐ Yes

Date of most recent transplant (MM/DD/YYYY)

INSURANCE INFORMATION

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

Name of Primary Insurance ______
Policy/Member # ______
Group # ______

Name of Secondary Insurance ______
Policy/Member # ______
Group # ______

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Date Collected (MM/DD/YYYY) ____/____/____

Time Collected ___:___ ☐ AM ☐ PM

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Specimen Draw Facility
☐ Quest Facility
☐ Patient Home
☐ Hospital/Clinic
☐ Other

Phlebotomist Name: ______ Phlebotomist Initials: ______

PATIENT BILLING ACKNOWLEDGEMENT

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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.

THIS SPACE IS FOR LABORATORY USE

☐ *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) ______

AUTHORIZED PHYSICIAN SIGNATURE - INTENT TO ORDER OR SUPPORT MEDICAL NECESSITY

Physician Signature ______ Date (MM/DD/YYYY) ______

All TruGraf® and Viracor TRAC® samples tested at Transplant Genomics, Inc., Lenexa, KS

eurofins | Transplant Genomics

Instructions for Use: Eurofins Transplant Genomics Test Request Form

Please fill out this information as completely and accurately as possible. Any missing information may result in a delay in processing. Further documentation may be needed to process claims.

Orange Section (Left) The details of your Transplant Genomics Account as given to you by your Transplant Manager of Customer Success Manager.

Orange Section (Right) Provider Specific Information. Please fill this out completely, including National Provider Identifier.

Orange Section (Bottom) Provider's Signature. This section is required. No signature will incur a delay in processing.

Green Section (Left) Patient Demographic information.

- MRN, Gender, Address, DOB are all required.
- E-mail address is optional.
- Preferred method of Contact: Choose between Phone, Text, or E-Mail. This will be how we contact the patient to confirm draw details and insurance information.
- Hospital Accession #, Prior Authorization #: Fill in these details if applicable.
- Primary Language: Indicate the patient's primary language.
- ICD-10 Code: Select which code is appropriate.

Green Section (right) Transplant Specific information

- Parent/Child Transplant: Check 'Yes' or 'No' as applicable to the patient's transplant. This affects the outcome of the test.
- Date of most recent transplant: Fill in the date of the most recent kidney transplant.

Blue Section Specific testing ordered, testing preferences, testing cadence, and insurance information

- Choose between TruGraf® Blood Gene Expression Test or Viracor TRAC® Kidney dd-cfDNA Test and indicate the purpose (Surveillance, For Cause, Private Pay/Medicaid). Please note that for patients with Medicare, the LCD Context of Use of the TruGraf® Blood Gene Expression Test is for surveillance, and the LCD Context of Use for Viracor TRAC® Kidney dd-cfDNA Test is for-cause. Utilization outside of these contexts may require further documentation or risk a declination of coverage. Please include Medical Necessity in Medical Notes.
- Standing Order (Optional): Start Date (Order), End Date: Provide the dates for the standing order. Start date should be the date of this form, and end date can be up to 1 year post signature.
- Frequency from first draw: Check the appropriate option.
- Sent Kit to Patient's Home: Check 'Yes' if a kit needs to be sent to the patient's home or 'No' if the draw is being completed at the hospital or draw clinic.
- Mobile Phlebotomist: Check 'Yes' if the patient requires a mobile draw, or 'No' if the patient will be drawing at the hospital, or at a draw clinic.
- Attach a copy of the front and back of insurance card(s). A facesheet with all insurance information is acceptable in lieu of data entry

Yellow Section Completed at time of collection

Purple Section Patient signature indicating they acknowledge that Transplant Genomics will bill their Insurance