HUMAN LONGEVITY CLINICAL LABORATORIES, LLC | HLIQ™ ONCOLOGY

PLACE WHOLE BLOOD BARCODE LABEL HERE

TEST REQUISITION FORM

*REQUIRED INFORMATION

PATIENT INFORMATION

☐ FIRST SUBMISSION OR ☐ IF SUBMITTED PREVIOUSLY

MRN

LAST NAME* | FIRST NAME* | MI

DOB* | MM/DD/YYYY

SEX*
☐ Male ☐ Female

CANCER DIAGNOSIS

ICD-10 CODE*

PHONE*

EMAIL ADDRESS

CLINICAL HISTORY
Please record on reverse side

ORDERING PHYSICIAN INFORMATION

CLIENT*

ORDERING PHYSICIAN* | NPI NUMBER

STREET ADDRESS* | CITY* | STATE* | ZIP*

PHONE* | FAX

EMAIL ADDRESS

BILLING INFORMATION

CHECK ONE

☐ INSTITUTION/CLIENT BILL

☐ MEDICARE NUMBER: ______________________________

☐ INSURANCE Name of Health Plan: ______________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

PLEASE ATTACH

☐ Front and Back Copy of Insurance Card (if applicable)

PATHOLOGY INFORMATION (REQUIRED IF TISSUE NOT PROVIDED)

HOSPITAL/INSTITUTION NAME | SUBMITTING PATHOLOGIST NAME

PHONE | FAX

NEED HELP?
Email: clientservices@humanlongevity.com
Phone: 844.838.3322 Ext.2

TEST MENU

☑ HLIQ ONCOLOGY

SPECIMEN RETRIEVAL

TUMOR (CHECK ONE)

☐ Ordering physician will contact pathology lab to request specimen

☐ Permission for HLI to contact pathology lab to request tumor specimen

NORMAL (CHECK ONE)

☐ HLI to facilitate blood specimen collection

☐ Blood specimen to be provided by client

SPECIMEN INFORMATION

PROCEDURE TYPE

TUMOR SPECIMEN SITE (PLEASE SPECIFY)

☐ Primary ☐ Metastasis ☐ Recurrence ☐ Lymph Node

SPECIMEN TYPE (TUMOR)

☐ FFPE Slides, quantity (stained/unstained) ☐ FFPE Blocks, quantity

☐ Other:

TUMOR SPECIMEN ID | DATE OF PROCEDURE | MM/DD/YYYY

SPECIMEN TYPE (NORMAL)
☐ Whole Blood (EDTA)
☐ Whole Blood (PAXgene)

COLLECTED DATE AND TIME

PLEASE ATTACH THE FOLLOWING

☐ Pathology Report ☐ Prior Genetic/Molecular Testing Results

PHYSICIAN AUTHORIZATION

My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit HLI to (a) perform the testing specified herein, (b) retain the test results and underlying data for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and underlying data and use or disclose such de-identified data for future unspecified research or other purposes, and (d) release the test results to the patient's third-party payer as needed for reimbursement purposes.

PHYSICIAN AUTHORIZATION * | DATE* | MM/DD/YYYY

HUMAN LONGEVITY
CLINICAL LABORATORIES, LLC

HLIQ™ ONCOLOGY

TEST REQUISITION FORM

*REQUIRED INFORMATION

CLINICAL HISTORY

AGE OF DIAGNOSIS, STAGE OR GRADE, CURRENT AND/OR PAST THERAPIES, FAMILY HISTORY OF CANCER

ASSIGNMENT OF BENEFITS, AUTHORIZATION RELEASE FORM (ALL NON SELF-PAYING PATIENTS)

PATIENT NAME	PATIENT ADDRESS		
PATIENT PHONE	CITY	STATE	ZIP

I hereby assign to **Human Longevity Clinical Laboratories, LLC** all my right to, title and interest in and to any and all medical and/or other health care benefits payable to or for me (including without limitation Medicare and Medicaid) on account of services provided to me by **Human Longevity Clinical Laboratories, LLC**, and hereby authorize payment to **Human Longevity Clinical Laboratories, LLC** on account of such benefits. I hereby authorize the release to **Human Longevity Clinical Laboratories, LLC** of any medical and insurance information necessary to process claims for services provided by **Human Longevity Clinical Laboratories, LLC** I hereby authorize **Human Longevity Clinical Laboratories, LLC** to pursue all necessary appeals of full or partial denials of payment in relation to services provided by **Human Longevity Clinical Laboratories, LLC**

In exchange for this assignment of benefits, **Human Longevity Clinical Laboratories, LLC** agrees to accept assignment of the medical and/or other health plan, insurer or other payer(s), i.e., and shall not balance bill me for the difference between my benefits and **Human Longevity Clinical Laboratories, LLC** retail charge for its services.

I acknowledge and agree that I remain responsible for applicable co-payments, deductibles and co-insurance as required by my medical and/or other healthcare benefits plans. If I receive payment of medical and/or other benefits on account of services provided by **Human Longevity Clinical Laboratories, LLC**, I shall pay **Human Longevity Clinical Laboratories, LLC** the full amount of that payment.

Note to patients: Human Longevity Clinical Laboratories, LLC billing and reimbursement professionals will work diligently to obtain payment from your insurance company. We will do our best to minimize any patient financial burden. For further assistance, please contact the **Human Longevity Clinical Laboratories, LLC Billing Department toll free at 844.838.3322 Ext.3.**

PATIENT/HEALTH CARE POWER OF ATTORNEY (SIGNATURE)	PRINT NAME OF PATIENT/HEALTH CARE POWER OF ATTORNEY
POWER OF ATTORNEY RELATIONSHIP TO PATIENT	DATE I MM/DD/YYYY

FOR INTERNAL USE ONLY

MASTER ACCESSION #	
	TUMOR RECEIVED DATE/TIME RECEIVED ☐ AM ☐ PM — **INITIALS**
	TUMOR APPROVED DATE/TIME RECEIVED ☐ AM ☐ PM — **INITIALS**
	NORMAL RECEIVED DATE/TIME APPROVED ☐ AM ☐ PM — **INITIALS**
	NORMAL APPROVED DATE/TIME APPROVED ☐ AM ☐ PM — **INITIALS**

COMMENTS