FirstSight CRC
Making Colorectal Cancer Truly Preventable

Test Requisition Form

CellMax Life

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1271 Oakmead Parkway
Sunnyvale, CA 94085

Step 1: Patient Information

Please fill in all fields unless specified. Incomplete forms may result in delay of sample processing.

Last Name: ______________ First Name: ______________ D.O.B.: MM/DD/YYYY Gender: M ☐ F ☐

Street: ______________ City: ______________ State: ______ Zip Code: ______

Primary Number: ( ) - ______ Secondary Number: ( ) - ______ Ok to contact patient for additional information? Y ☐ N ☐

Alternate Contact Name: ______________ Relationship: ______________ Alt. Contact Number: ( ) - ______

Patient E-mail Address: ______________

Blood Draw Date: MM/DD/YYYY Blood Draw Time: ______ AM/PM

Step 2: Patient Insurance / Billing Information

Policyholder Name: ______________ Policyholder D.O.B.: MM/DD/YYYY Relationship to patient: Self ☐ Spouse ☐ Other ☐

Type: Insurance ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other ☐ Self Pay ☐

Insurance Carrier/Program: ______________

Alternate Contact Name: ______________ Relationship: ______________ Alt. Contact Number: ( ) - ______

Step 3: Patient Assignment of Benefits Notice (AOB)

I authorize CellMaxLife to bill my insurance/health plan and furnish them with my test order information, my test results, or other information requested for reimbursement, to appeal any reimbursement denial, and to authorize all reimbursements to be paid directly to the laboratory in consideration of services performed. I understand that I am responsible for any amount not paid, including amounts for noncovered services. By signing below, I agree that CellMax can share information with CellMax's partners and affiliates as needed.

Patient Signature: ______________ Date: MM/DD/YYYY

Step 4: Provider Information

Last Name: ______________ First Name: ______________ Practice Name: ______________

Street: ______________ City: ______________ State: ______ Zip Code: ______

Prescriber NPI: ______________ Office Number: ( ) - ______ Fax Number: ( ) - ______

Step 5: Test Information

Test Name: CellMax FirstSight

Description: Blood test for the likelihood of colorectal cancer or adenomatous polyps

ICD10 Code: **Z12.11** and **Z12.12** (Encounter for screening of malignant neoplasm of colon [**Z12.11**] and rectum [**Z12.12**])

Other (please specify): ______________

The above codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test, regardless of whether the code is listed above or not.

Step 6: Provider Authorization

I, ______________ attest that I ordered the FirstSight test for my patient, ______________. In my opinion this test provides medically necessary information needed to evaluate my patient using current Medical guidelines. I have provided CellMax Life my patient's current insurance information and I understand CellMax Life will be billing the patient's insurance company and accepting assignment on this claim. By signing below, I certify that I am a licensed medical professional authorized to order FirstSight. I acknowledge that the test is medically necessary and that the patient is eligible to receive FirstSight. I accept responsibility for maintaining the privacy of test results and related information as required by HIPAA.

Provider Signature: ______________ Date: MM/DD/YYYY

For CellMax Life Use
Sample Received:
Accessioned By:

Fax Completed Form to 408-462-9677

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