CCC DIAGNOSTICS
Saving Lives and Life Savings
3918 Vero Road, Suite B, Baltimore, MD 21227 Phone: (410) 633-4885 Fax: (410) 633-4502 WWW.CCCDIAG.COM

DirectHit™ Test Panel For Breast Cancer Requisition Form

Drug Response Indicator Test

Patient Name: First Middle Last	Date of Birth-MM/DD/YYYY

I. ACCOUNT INFORMATION

☐ First submission ☐ Resubmission

*Ordering Physician (Print Name):	Hospital/Institute:	
*Ordering Physician Signature:	Address	
*Ordering Physician E-mail:		
*Ordering Physician Tel. #: Fax #:	City:	State: ZIP
Send report to Physician's ☐ E-mail above ☐ Address ☐ Fax ☐ Special instructions below		
Special instructions:		

II. PATIENT INFORMATION (Required)

Patient ID/Slide #	Gender		Race				Date of Birth
	☐ Male	☐ Female	☐ AA	☐ C	☐ H	☐ Other	

Disease Status (Check One): ☐ Progressive ☐ Complete Remission ☐ Partial Remission ☐ Stable

Surgery: ☐ Yes ☐ No **Radiation Therapy**: ☐ Yes ☐ No **Hormonal Therapy**: ☐ Yes ☐ No

III. Billing Information

Submitting Diagnosis Code

Patient Self Pay credit card ☐ on account ☐ not applicable ☐	**Medicare** ☐ **Medicaid** ☐
Name on Credit Card	☐ In-Patient ☐ Outpatient
CC # Exp. Date	☐ non-Hospital Patient ☐ Signed ARN attached

Patient Signature Authorization to bill credit card___________________________________ **Date** _________________________

Private Insurance ☐ Complete Page 2

IV. Pathology Information (Required)

Tissue Collection Date (required) **Body Site:** **Paraffin Block ID #**

Primary Diagnosis: ☐ Breast Cancer ☐ Other: **ICD-9 / ICD-10** ___________ ___________ ___________ ___________

Stage _____ **Grade:** ______ **T:**_____ **N:**_____ **M:** _____ **G:**_____ **/** ☐ In-Situ ☐ Invasive ☐ Ductal ☐ Lobular Metastatic ☐ yes ☐ no

Tumor **Size:** **(cm)** **Nodal status (positive/Total):**

Slide Preparation Date : **# of unstained slides for test:** ☐ 6 ☐ other

Pathologist **Tel #** **Fax #**

Pathologist Signature **Date** **e-mail**

*These diagnostic laboratory tests must be ordered by a treating physician (or their authorized representative) who is providing consultation or treatment recommendations for a patient with breast cancer. Signature of the physician above certifies that intention to treat or not to treat with chemotherapy is contingent, at least in part, on the results of this series of tests. If the ordering physician is not the treating physician, then the ordering physician who signs this form confirms that the treating physician has ordered the DirectHit™ Test Panel for Breast Cancer.
**This test was developed and its performance characteristics determined by CCC Diagnostics LLC. The analyte-specific reagents utilized in the test procedure have not been cleared by the U.S. Food and Drug Administration (FDA) nor does the FDA require user certification for their use. This service is an adjunct to the clinical evaluation of the referring physician and does not represent a final diagnosis. Its role in the management of individuals is left to the discretion of the referring physician.

CCCD Use Only

Patient Last Name: _____________________ **Confirmation #**________________ **Account No.** _________________

Sample must be received by: ____________________ **to meet scheduled Test Date** __________ **Turnaround time: 6 business days.**

Date/Time Rec'd: _________________ **Accession No.** _________________ **Within Limits:** ☐ yes ☐ no **Rec'd By:** __________

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INSURANCE VERIFICATION / AUTHORIZATION SHEET

Patient: ___________________________________ Date of Birth: ________________________________

SS# ______________________________________ Referring Physician _______________________________

Reason for Test: ____

Test Facility: ____

PRIMARY INSURANCE COMPANY ____ Phone # _________________

Policy # _________________________ Group # _____________________ Effective Date _________________

Claims Mailing Address: ____

Verification Date: _________________________ Verified by: ___________________________

Spoke To (full name): ____

Co-Pay: ________________ Need a REFERRAL? _____ YES _____ NO Certification? _____ YES _____ NO

Authorization? _____ YES _____ NO Authorization # _______________________________________

Are there any Pre-Existing Conditions? _____ YES _____ NO

What are the conditions? ____

Is the pre-exiting condition less than 30 days old? _____ YES _____ NO

Is there a "Wait Time" due to any investigations pending or otherwise? _____ YES _____ NO

TREATMENT PLAN REQUIRED? Y N LENGTH OF TIME :___________________________

SECONDARY INSURANCE COMPANY ____ Phone # ___________________________

Policy # _________________________ Group # _____________________ Effective Date _________________

Claims Mailing Address: ____

Spoke To (full name): ____ Co-Pay?: _______________

PATIENT'S AUTHORIZATION

I authorize the release of medical information to insurance carriers and / or their agents. I also authorize payment of medical benefits to the physician or supplier for services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent.

I understand that if a service is not a covered benefit and that without an authorization or referral form from my HMO/IPA/PPO, I will be financially responsible for charges I incur in full.

_____________________________________ _____________________________________

SIGNATURE OF SUBSCRIBER DATE

ATTACH FRONT AND BACK COPIES OF INSURANCE CARD

ATTACH COPY OF DRIVERS LICENSE

CCCD Use Only
Patient Last Name: ______________________ Confirmation #________________ CCCD Accession # ___________________