AlloSure® KIDNEY

PLACE ACCESSION LABEL HERE

AlloSure for Kidney Transplant Test Requisition Form

If you need help finding a blood draw center for AlloSure Kidney, call 1-888-255-6627.

DRAW SITE NAME	
DRAW DATE	PHLEBO. INITIALS

All items in red required. Missing information may delay testing

Ordering Physician: Complete sections A, B, C (for optional Standing Order), D, E, F (for additional comments) and G.
Phlebotomists: Complete red boxes, right, with draw site, draw date, and your initials.
Lab: Affix first accession label from tube and accession labels card in top right corner, as indicated.

Numbered rows 1-6, 7 (if living related) 9 and 11 contain fields that MUST be completed. MISSING INFORMATION MAY DELAY TESTING.

A. PATIENT AND PRESCRIBER INFORMATION

1	Patient Last Name		Patient First Name	MI	MRN
2	DOB (mm/dd/yyyy)	Biological Sex: ☐ Male ☐ Female	Patient's Primary Phone		Social Security Number
3	Patient's Address		City	State	Zip
4	Ordering Physician		NPI		

B. CLINICAL INFORMATION

5	Transplant Date (mm/dd/yyyy)	ICD-10 code: ☐ Z94.0 ☐ T86.10 ☐ Other:_____
6	**CHOOSE ONE**: ☐ Deceased donor ☐ Living related donor **(complete row 7 below)** ☐ Living unrelated donor	☐ **HOSPITAL DRAW ONLY:** Check if this is an inpatient, if testing order is <14 days from inpatient discharge, and/or if patient coverage is under private insurance case rate. In such cases, the hospital may be billed for the test.
7	**CHOOSE ONE**: If living related donor, please select the relationship of donor to recipient. ☐ Parent ☐ Child ☐ Grandparent ☐ Grandchild ☐ Sibling ☐ Half-sibling ☐ Fraternal twin ☐ Identical twin ☐ Aunt ☐ Uncle ☐ Great aunt ☐ Great uncle ☐ Niece ☐ Nephew ☐ Great niece ☐ Great nephew ☐ Cousin ☐ Other (specify):_____	

C. STANDING ORDER

8	**Check appropriate schedule for AlloSure standing order (12 month maximum):** ☐ AlloSure Routine Testing Schedule post transplant, Year 1: Months 1, 2, 3, 4, 6, 9, 12; Years 2+: Quarterly ☐ Custom Standing Order: Check a box below for each month the patient should have an AlloSure test:												Start Date (mm/dd/yyyy)
	☐ Jan	☐ Feb	☐ Mar	☐ Apr	☐ May	☐ Jun	☐ Jul	☐ Aug	☐ Sep	☐ Oct	☐ Nov	☐ Dec	End Date (mm/dd/yyyy)

D. PATIENT INSURANCE INFORMATION — Attach front/back copies of insurance card and/or facesheet

9	Name of Insured	Insurance Provider	Member ID #
10	Secondary Insurance Provider	Name of Insured	Member ID #

E. TRANSPLANT CENTER AND/OR REFERRING LABORATORY INFORMATION

11	Transplant Center Information: Contact Name	Facility Name	Phone
	Referring Laboratory Information: Contact Name	Facility Name	Phone

F. ADDITIONAL INFORMATION

12	

G. ORDERING PHYSICIAN AUTHORIZATION AND ACKNOWLEDGMENT

Your signature constitutes a Statement of Medical Necessity (SOMN) and your attestation of the following: (1) accurate clinical information has been entered above (2) the patient meets the assay criteria (3) the test is medically necessary and test results will be used with other clinical data to assess the probability of allograft injury, rejection or otherwise to inform clinical decision making and to aid in guiding treatment decisions for the patient. (4) the patient has consented for this test to be performed and for CareDx to release test information when necessary to obtain reimbursement. (5) Physician or physician's delegate has the authorization to sign support forms and documents on behalf of the ordering physician for CareDx Orders (electronic, PA signature requirements).

Acknowledgment: Your signature on this form indicates that the physician or physician's delegate has obtained all requisite authorizations from the patient necessary to authorize the release of any medical and insurance information necessary to process claims for services provided by CareDx, Inc., and has obtained all requisite authorizations to assign the right of the patient to, and authorize payment to CareDx, Inc. for all services provided by CareDx, Inc. CareDx, Inc. is authorized to pursue all necessary appeals of full or partial payment on behalf of the patient with his or her health insurance company in relation to services provided by CareDx, Inc. In exchange for this assignment of benefits, CareDx, Inc. agrees to accept assignment from my health insurance company as payment in full.

Authorized Ordering Physician Signature:_____ **Date:**_____

CareDx®

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