SILBIOTECH, INC.

BBDRisk Dx™ Test Request Form

7858 Beechcraft Ave
Gaithersburg, MD 20879
Phone: 301-787-1216
Fax: 301-987-9724
http://www.breasthyperplasiacancerrisk.com

Section 1. Submission Status

X First Submission ☐ Resubmission-Associated Requisition #_____

Section 2. Physician Information

Practice Account Details:
Address: Breast Center, 111 Main Street, City, State, Zip code: 00000

Phone: 555-000-0000 Fax: 555-000-0001
Ordering Physician Name: Jane Jones, M.D
Contact Name: Ms. Smith
Contact Phone: 555-000-0002
Contact email: smithXXXX@university hospital.edu
Send Report by: Mail ☐ Fax ☐ email X☐

Section 3. Physician Signature

I represent that I am treating this patient as the physician of record and authorizing the performance of the test identified on this order. I have concluded that the test I am ordering is medically necessary for treatment of this patient. I anticipate that the test will provide predictive information which has not been obtained already. This order form is part of the medical record, is consistent with other entries in the record and accurately describes the reason I am ordering the test. In submitting this order, I acknowledge that I have obtained the consent from the patient for Silbiotech, Inc. to release the test results to the patient's third party payer when necessary as part of the reimbursement process. I have read and agree to be bound by Silbiotech, Inc.'s general terms and conditions.

Ordering Physician Signature:
Jane Jones, M.D Date: 7/7/2017
Print Name: Jane Jones, M.D

SAMPLE

Section 4. Patient Information

Doe, Missie S.
Patient Name: Last First Middle

456 Market Street
Address

Anycity S[illegible] 00000 USA
City State Zip Country

Fax: 000-000-0000

5-6-1979 555-555-5555
Date of Birth Patient Phone

S2017-11111 000-00-0000
Medical Record# SSN#

Section 5. Billing Information

Complete the following and attach a copy of front and back of insurance card

Billing Type: X☐ Private Insurance ☐ Medicare ☐ Patient

work-place insurance XYZ123
Primary Insurance Name Member ID

12X45V 555-555-7777
Prior Authorization # (if available) Phone

Second Insurance ABC575
Secondary Insurance Name Member ID

Relationship to Insured: X ☐ self (skip section below) ☐Spouse ☐ Dependent

Other: Insured DOB _____ Insured SSN _____

Section 6. Specimen Information

Collection Date: 6-6-2017 Specimen Type: ☐ FFPE Block X☐ FFPE Slides X☐ Right Breast ☐ Left Breast:

Submitting Diagnosis (check all that apply): X☐ ADH X ☐ ALH ☐ UDH X☐ ULH ☐ PAPILLOMA ☐ Sclerosing Adenosis

Please include Pathology Report with the Test Request Form and an H& E slide from the selected block(s)

Section 7. Pathology Information

Practice Account Details:
Address: Pathology Labs, 354 Elm Street, City, State, Zip:

Phone: 555-222-5555 Fax: 555-222-5556
Submitting Pathologist Name: Doctor Doctor, M.D
Block Return Location (If different):
Phone:
Contact Name:

Specimen ID(s):
1) S-06980 2) S-246789
6-6-2017
Date of Surgery Date Pulled from Archives

Additional comments