MAMMOCHECK™ ORDER FORM

MILAGEN, INC
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p: 510-597-1244 | Milagen.com
TIN: 68-0435863 NPI: 1306558044

Provider & Order Information

Recommended to type all information.

PROVIDER INFORMATION

Healthcare Organization Name: _____

Doctor - First Name:_____Last Name:_____

NPI #: | | | | | | | | | | |

Address: _____

City, State, Zip: _____

Phone Number: _____

Email: _____

ORDER INFORMATION

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience.Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

ICD-10 Code:

○ Z12.39 (Encounter for other screening for malignant neoplasm of breast.

○ Other(s) _____

Certification

I am a licensed healthcare provider authorized to order MammoCheck. This test is medically necessary and the patient is eligible to use MammoCheck. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Milagen to obtain reimbursement for MammoCheck and to directly contact and collect additional samples from the patient as appropriate.

_____

Ordering Provider Signature ***Date of Order***

Patient Demographics

Attach a copy of the front & back of primary and/or secondary insurance cards.

Patient ID/MRN: _____

Name - First:_____Middle:_____Last:_____

DOB (mm/dd/yyyy): _____ Sex: ○ Male ○ Female

Phone Number *(required)*: _____
○ Home ○ Mobile ○ Work

Language Preference *(optional)*: _____

Mailing Address: _____

_____

City, State, Zip: _____

If self-paying, what is preference: ○ Check ○ Credit Card

Billing Address: _____
☐ *Same as Mailing*
_____

City, State, Zip: _____

PATIENT ETHNICITY AND RACE

The completion of this section is optional.

Is your patient of Hispanic or Latino origin or descent? ○ Yes ○ No

Please mark one or more to indicate your patient's race:

○ White ○ Black or African-American ○ Asian ○ Native Hawaiian or other Pacific Islander ○ American Indian or Alaska Native

Patient Insurance/Billing Information

Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Does patient wish Milagen to bill their insurance? ○ Yes *(complete below)* ○ No *(patient will self-pay)*

Policyholder Name: _____ Policyholder DOB: _____ Relationship to patient: ○ Self ○ Spouse ○ Other

Primary Insurance Carrier: _____ Type: ○ Private ○ Medicare ○ Medicare Advantage ○ Medicaid ○ Tricare

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ Group Number: _____ Plan: _____

Prior-Authorization Code *(if available)*: _____

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

I authorize Milagen to bill my insurance/health plan and furnish them with my MammoCheck order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to Milagen and authorize Milagen to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider.I further understand that if I am a Medicaid enrollee in a state where Milagen is enrolled as a Medicaid provider, Milagen will accept as payment in full the amounts paid by the Medicaid program,plus any deductible,coinsurance or copayment which may be required by the Medicaid program to be paid by me.

Patient Signature: _____ **Date:** _____

Email completed form to clia_lab@milagen.com

For Lab Use Only	
Sample Collected: __/__/____	Sample Received: __/__/____