BELAY DIAGNOSTICS

TEST REQUISITION FORM

Complete and insert in shipping kit, or:
Email: contact@belaydiagnostics.com
Fax: (800) 501-9246
Questions? Call (331) 320-0155

If any information is incomplete or missing, testing may be delayed.

CSF SAMPLE COLLECTION
≥6 mL (adults), ≥4 mL (pediatrics)

Date*: (MM/DD/YYYY)

Time*: XX:XX ◯ am ◯ pm

Belay Lab Use Only

1. ORDERING CLINICIAN INFORMATION *(*required field)*

Clinician Name*	**NPI #***	**Facility/Institution Name***		
Street Address		City	State	Zip
Phone #		**Email***		
Additional Recipient		Fax or Additional Recipient Email		

2. PATIENT INFORMATION *(*required field)*

First Name*	MI	**Last Name***	Medical Record #	
DOB* (MM/DD/YYYY)	Sex at Birth ◯ Male ◯ Female	**Email***	**Primary Phone #***	
Street Address*		**City***	**State***	**Zip***

Ancestry:
◯ White/Non-Hispanic ◯ Hispanic/Latino ◯ Middle Eastern ◯ Asian ◯ Black/African American ◯ Other: _____

3. TEST SELECTION *(required, select all that apply)*

☐ **Summit™ 2.0** *520 genes (SNVs, MNVs, Indels) , 62 CNVs , 28 Fusions , TMB and MSI*
☐ **Ascent™** *Chromosome arm-level and focal-level losses/gains (aneuploidy)*
☐ **Vantage™** *MGMT promoter methylation status*

4. BILLING INFORMATION *(*required field)*

Place of Service*
◯ Inpatient
◯ Outpatient

Traditional Medicare?* ◯ Yes ◯ No

If yes and outpatient, ***patient must sign Medicare ABN*** *in test kit or at this link: belaydx.com/abn*

5. PATIENT HISTORY *(*required field): Please complete in full to support accurate diagnosis and billing*

Provisional Diagnosis*

Does patient have a history of cancer? ◯ Yes ◯ No

If yes, enter primary cancer data, if known:
◯ Brain ◯ Lymphoma
◯ Breast ◯ Melanoma
◯ Lung ◯ Other (please specify): _____

CA Stage/Grade: **Date of Diagnosis:**

Is the patient (check all that apply):
◯ Recurrent ◯ Advanced stage/grade
◯ Refractory ◯ Relapsed
◯ Metastatic ◯ Other (please specify): _____

Was CSF cytology testing performed? ◯ Yes ◯ No ◯ In Progress *If "Yes", results are:* ◯ *Negative* ◯ *Positive*

Reason(s) for testing (check all that apply):
◯ Guide tumor grading/classification and treatment planning ◯ Assess treatment resistance/progression
◯ Systemic treatment or clinical trial participation ◯ Other _____

Tissue biopsy/resection completed? ◯ Yes ◯ No ◯ Unknown

If not completed, select reason(s): ◯ Infeasible/contraindicated ◯ Patient declined ◯ Other _____

	Yes	No	Unk
Has genomic profiling on tumor been completed for patient? *(If "Yes", attach report)*	◯	◯	◯
Has patient received/currently receiving chemotherapy?	◯	◯	◯
Has patient received/currently receiving radiotherapy?	◯	◯	◯

6. ICD-10/DIAGNOSTIC CODES *(one or more codes required)*

www.icd10data.com/ICD10CM/Codes/R00-R99/R90-R94/R94-/R94.02

◯ C 70.0 Malignant neoplasm of cerebral meninges
◯ C 70.1 Malignant neoplasm of spinal meninges
◯ C 70.9 Malignant neoplasm of meninges, unspecified
◯ C 71.0 Malignant neoplasm of cerebrum, except lobes and ventricles
◯ C 71.1 Malignant neoplasm of frontal lobe
◯ C 71.2 Malignant neoplasm of temporal lobe
◯ C 71.3 Malignant neoplasm of parietal lobe
◯ C 71.4 Malignant neoplasm of occipital lobe
◯ C 71.5 Malignant neoplasm of cerebral ventricles
◯ C 71.6 Malignant neoplasm of cerebellum
◯ C 71.7 Malignant neoplasm of brain stem
◯ C 71.9 Malignant neoplasm of brain, unspecified
◯ C 72.0 Malignant neoplasm of spinal cord, cranial nerves and other parts of CNS
◯ C 79.31 Secondary malignant neoplasm of the brain
◯ C 79.32 Secondary malignant neoplasm of cerebral meninges
◯ C 79.40 Secondary malignant neoplasm of unspecified part of nervous system
◯ C 79.49 Secondary malignant neoplasm of other parts of nervous system
◯ G 96.198 Other disorders of meninges, not elsewhere classified
◯ Other: _____

7. ORDERING CLINICIAN AUTHORIZATION *(*required field)*

I am the patient's treating physician and my signature certifies: (1) I am authorized under applicable law to order the tests on this test requisition form; (2) the clinical information entered on this form is accurate and this test is medically necessary; (3) I have prepared documentation demonstrating the medical necessity of the test, included it in the patient's medical record, and will make it available to Belay upon request; (4) I will use the test results to inform my treatment decisions and medical management of the patient; (5) I have explained the nature, purpose, potential benefits, risks, and alternatives to the patient, and the patient has had the opportunity to ask questions regarding the test including the collection, use, and disclosure of their sample and health information; and (6) I have obtained all consents, authorizations and permissions required by applicable state and federal law, for Belay to perform the testing ordered and for the collection, use and sharing of the patient's data and sample, as further described in Belay's Notice of Privacy Practices, available at belaydx.com/privacy, and will provide a copy of the patient's consent to Belay upon request.

Ordering Clinician/Authorized Signature*: **Date*:**

IMPORTANT: PLEASE INCLUDE THE FOLLOWING WITH YOUR ORDER *(*required field)*
☐ **Insurance Information*** ☐ **Relevant Clinical Notes*** ☐ **Pathology Report*** ☐ **Genomic Profiling Report***

Missing documents may delay processing and billing.

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