



PLACE BARCODE LABEL HERE

DO NOT MIX LABELS BETWEEN PATIENTS

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Adolescent Idiopathic Scoliosis Test Requisition Form
(This form is available in an editable format at www.axialbiotech.com/forms)

PHYSICIAN INFORMATION

Institution Name:
Dept/Clinic Name:
Physician Name: NPI:
Address:
Address 2:
City: State: Zip: Fax:
Phone: Email:
Specialty: Pediatric Orthopaedic Orthopaedic Spine Pediatrician Family Practice Other:
Physician Signature (required): Date:

Medical professional authorization and consent: I hereby authorize testing for this patient. I have supplied information regarding molecular testing and the patient has given consent for molecular testing to be performed. Does the patient consent to use of their sample for validation research to improve scoliosis testing? Y N Consent is implied if a box is not marked. (New York law requires residents to indicate consent.) Your signature constitutes a certification of the following: When ordering SCOLISCORE™ for which reimbursement from Medicare, Medicaid or other third party payors will be sought by Axial Biotech, I certify that the above ordered prognostic test is reasonable and medically necessary for the diagnosis, care and treatment of this patient's condition. I also hereby authorize Axial Biotech to send on my behalf this patient's test results to the patient's third party payor in connection with an appeal of a reimbursement denial or other reimbursement matter; but only where Axial Biotech has made prior attempts to obtain reimbursement without the release of such test results.

PATIENT INFORMATION

Patient Name: Medical Record/Patient #:
Address:
City: State: Zip: Phone:
Gender: M F DOB: Race: Asian Black Caucasian Hispanic Other:
Cobb Angle: Menarche: Yes No N/A

Required: I certify that this patient is not skeletally mature and that their diagnosis is AIS (ICD-9CM 737.30) Check Here:

SAMPLE INFORMATION

Specimen Collection Date: Specimen Collected By:

BILLING INFORMATION

Please call a SHARP representative at 1-877-742-7710 for questions or payment options.

Method of Payment (select one): Bill Insurance Bill Account Uninsured/Self Pay Uninsured/Medically Indigent (form required)
Responsible Party Name: Relationship to Patient: Parent/Legal Guardian Other:
Responsible Party Address:
City: State: Zip: Phone:
Primary Insurance: Member ID#: Group #:
Primary Insurance Address:
City: State: Zip: Phone:
Secondary Insurance Yes No Medicaid Cardholder #:
Copy of front and back of patient's insurance card(s) (required) Copy of front and back of insured's drivers license (required)
Responsible Party Signature (required): Date:

I hereby authorize the release of medical information related to the services described above and authorize payment directed to Axial Biotech, Inc.

Important: All information must be filled out on form before test will be completed.

REQUISITION FORM INSTRUCTIONS

Section I: Physician Information

A. Please fill-in all fields with applicable information.

Note: Reports cannot be sent to PO Boxes or e-mailed.

B. Signature of Ordering Physician (Required)

1. Sign and date the Requisition Form and print Ordering Physician's Name. The signature must be of an Ordering Physician or the Physician's Authorized Representative.
2. To be medically necessary, diagnostic laboratory tests must be ordered by a treating physician (or the authorized representative) who provides a consultation or treats a patient for a specific medical problem and who uses the findings in the management of the patient.

Section II: Patient Information

A. Please fill-in all fields with applicable information.

Section III: Sample Information

A. Please fill-in all fields with applicable information.

Section IV: Billing Information

- A. Please fill-in all fields with applicable information.
- B. Please call a SHARP representative at 1-877-742-7710 for questions or payment plans.
- C. Form with physician's signature is required for medically indigent cases. Please contact 1-877-742-7710.
- D. Select only one method of payment.
- E. Please include a copy of the front and back of the Primary Insurance, Secondary Insurance, Medicaid, or Medicare cards.
- F. Please include a copy of the front and back of the insured party's drivers license.
- G. Please do NOT include any other personal information (example: social security number).
- H. Signature of responsible party (required).

SPECIMEN INSTRUCTIONS

- A. Please follow the instructions that are found in the DNA Genotek Oragene OG-300 Saliva Collection Kit. (Important: Please ensure that patient fills vial with saliva to indicated fill line.)
- B. Remove the bar code labels from the SCOLISCORE™ AIS Prognostic Assay Kit and place a bar code label on:
- a. Saliva Specimen Vial (place label lengthwise.)
 - b. Requisition Form

Note: The SCOLISCORE™ report is based upon Axial Biotech's analysis of the submitted specimen and information provided on the Requisition Form. Additional materials and information that may be submitted with the specimen are not considered in analyzing the specimen or preparing the report.

DOMESTIC SHIPPING INSTRUCTIONS

- A. Place the SCOLISCORE™ specimen into the Bio-Hazard specimen bag and seal.
- B. Place the specimen bag and specimen into the bottom of the pre-paid US Mail Shipping Box.
- C. Place the Requisition Form into the SCOLISCORE™ Envelope and place into the US Mail Shipping Box.
- D. Remove the backing off of the adhesive strip on the inside of the shipping box and firmly seal shipping box.
- E. Place the shipping box into any US Mail box or provide to postal worker.

Note: This test is performed pursuant to an agreement with Roche Molecular Systems, Inc.

Questions? Call Axial Biotech, Inc. at (877) 294-2598.