



I. ASSAY / SUBMISSION TYPE

ASSAY: BREAST COLON SUBMISSION: FIRST RESUBMISSION — Associated Requisition

II. ORDERING PHYSICIAN INFORMATION

ORDERING PHYSICIAN NAME
John Smith, M.D.
CONTACT NAME
Shannon
PHONE
555-111-2222 FAX
555-222-5555

III. ADDITIONAL PHYSICIAN (Name will appear on report)

ADDRESS
CITY STATE ZIP COUNTRY
PHONE FAX

IV. PATIENT INFORMATION

PATIENT NAME: Last, First MI
Doe Jane S
DOB (MM/DD/YYYY) **02/16/1965** SEX Male Female
MEDICAL RECORD / PATIENT NUMBER **921857** SSN **000-00-0000**
ADDRESS 1 **333 Main Street**
ADDRESS 2
CITY **Anytown** STATE **ST** ZIP **00000** COUNTRY **USA**
HOME PHONE WORK PHONE
CELL PHONE **555-332-1111**

V. BILLING INFORMATION

SUBMITTING DIAGNOSIS **breast cancer**
 PRIVATE INSURANCE (Attach Front/Back copy of insurance card.)
Primary **Blue Cross of State**
MEMBER ID **555-1111**
Secondary **PremiumPointe Health**
MEMBER ID **555-0000**
Prior Authorization #

IOD-9 CODE **174.9**
 PATIENT SELF-PAY Check (US), certified funds, money order, or credit card
Name on Credit Card
Credit Card #
Expiration Date (MM/YY)
 BILL PATHOLOGY ACCOUNT Restricted to contracted accounts on file at Genomic Health

VI. BENEFITS INVESTIGATION — SERVICE OPTIONS (SELECT ONE)

1. No Investigation Required. 2. YES Investigate — Proceed with test and REPORT RESULTS. 3. YES Investigate — Proceed with test and HOLD FINAL PROCESSING pending patient approval. (May extend turn-around-time for report results.)

STATEMENT OF MEDICAL NECESSITY (Please state why the patient needs this test and any past experiences using OncoType DX to support treatment decisions.)

Comments on why the test is needed to make your treatment decision...

VII. SPECIMEN RETRIEVAL — SERVICE OPTIONS (SELECT ONE)

1. I want Genomic Health to request the specimen. (COMPLETE the information below.) 2. I will arrange having the specimen sent. (FAX this form to Pathology.)

LOCATION OF SPECIMEN **BayLabs, Inc.** PHONE **555-222-1212** FAX **555-222-1212** CONTACT NAME

VIII. PHYSICIAN SIGNATURE & SPECIMEN STATUS — REQUIRED

ORDERING PHYSICIAN SIGNATURE
X John Smith MD. DATE (MM/DD/YYYY) **02/01/2010**
PRINT NAME **John Smith, M.D.**

Please select specimen status for the OncoType DX cancer assay selected above:
BREAST ASSAY: Node Negative Node Positive (1-3 Nodes)
 Micromets (pN1mi: 0.2 – 2.0mm) Node Positive (4+ Nodes)

Your signature constitutes a Certification of Medical Necessity and a certification that you have obtained the patient's consent for Genomic Health Inc.'s release of the test results to the patient's third party payer when necessary as part of the reimbursement process. Please read Section VIII on the reverse side for full details. By signing this form you are stating that *either* (1) the patient meets the criteria stated in Section VIII on the reverse side of this form OR (2) if the patient does not meet these criteria, that you have entered the reason(s) in the Exception Criteria space provided. A Genomic Health representative may contact you should your patient not meet these criteria.

COLON ASSAY: T4: Yes No Unknown
MSI-H or MMR-D: Yes No Unknown

EXCEPTION CRITERIA

IX. PATHOLOGY INFORMATION

ACCOUNT
BayLabs, Inc.
SUBMITTING PATHOLOGIST NAME
Bill Smith, M.D.
PHONE **555-222-1212** FAX **555-222-1222**

SPECIMEN IDs: The OncoType DX assay will be completed on the specimens in the order listed below. Only one specimen is typically required.
MULTIPLE PRIMARIES: Yes No
1) **SP-07-1111A** 3)
2) DATE OF SURGERY (MM/DD/YYYY) **01/30/2010** 4)
DATE BLOCK PULLED FROM ARCHIVE (Required for Medicare.)

BLOCK RETURN LOCATION (if different then the Pathology/Account listed above)

PHONE **555-222-1213** CONTACT NAME **Jessie**