DERMTECH MELANOMA TEST ORDER REQUISITION FORM

DermTech

PIGMENTED LESION ASSAY (PLA) - LINC00518 & PRAME

12340 El Camino Real
San Diego, CA 92130

CLIENT SERVICES:
(858) 788-1310

SAMPLE COLLECTION INFORMATION

COLLECTED BY

DATE / /

KIT NUMBER

PATIENT INFORMATION

LAST NAME | FIRST NAME | M.I.

ADDRESS

CITY | STATE | ZIP

MOBILE PHONE | EMAIL

DATE OF BIRTH / / | AGE | SEX | MEDICAL RECORD NUMBER

BODY SITE *Not intended for use on palms, soles, or mucous membranes.*

BILL TO ☐ INSURANCE ☐ PATIENT UNINSURED ☐ PATIENT SELF-PAY

PATIENT INSURANCE

ATTACH A COPY OF PRIMARY AND/OR SECONDARY INSURANCE CARDS (FRONT & BACK)

SUBSCRIBER NAME

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ DEPENDENT

DATE OF BIRTH / / | SEX ☐ MALE ☐ FEMALE

SUBSCRIBER SECONDARY INSURANCE

ATTACH A COPY OF INSURANCE CARD (FRONT & BACK)

SUBSCRIBER NAME

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ DEPENDENT

DATE OF BIRTH / / | SEX ☐ MALE ☐ FEMALE

PRACTICE INFORMATION

PRACTICE NAME

HEALTH CARE PROVIDER | NPI NUMBER

ADDRESS / LOCATION

CITY | STATE | ZIP

PHONE | FAX

LESION EXHIBITS

Please check the ABCDE criteria that the lesion exhibits:

☐ Asymmetry ☐ Diameter
☐ Border ☐ Evolving
☐ Color

ICD-10 CODE

☐ D48.5 Neoplasm of uncertain behavior of skin

☐ D49.2 Neoplasm of unspecified behavior

☐ Other ______________

NOTE: For the convenience of the ordering health care provider, the above ICD-10 codes are listed without any express or implied warranty of any kind. Health care providers are not required to use these codes but should report the most clinically appropriate diagnostic code(s) that best describe the reason for performing the test.

HEALTHCARE PROVIDER SIGNATURE AND ACKNOWLEDGEMENT

This test is medically necessary for the evaluation and treatment of my patient for a lesion suggestive of melanoma, with one or more ABCDE criteria and is for a patient having skin type Fitzpatrick I, II or III. The lesion was approximately 5mm or larger and skin was intact, not scarred or site of previous biopsy, is not: on palms, soles, or mucous membrane, and is not a carcinoma, seborrheic or actinic keratosis, ulcerated, bleeding, psoriasis, eczema or similar appearance. I certify that I have the requisite knowledge, skill, and experience to evaluate and biopsy pigmented lesions.

HEALTH CARE PROVIDER SIGNATURE

DATE (MM/DD/YYYY)

PATIENT AUTHORIZATION TO APPEAL INSURANCE DETERMINATION *OPTIONAL*

I hereby request and authorize my healthcare provider ordering the DermTech laboratory test and my insurance carrier (each, a "Disclosing Party") to release my protected health information ("PHI"), including medical records, histories, insurance, payment and other reasonably requested information to DermTech Inc. (the "Recipient"). The purpose of this authorization is so that DermTech may appeal on my behalf any denial of claims by my insurance carrier related to the DermTech laboratory test, and for DermTech to support me related to the insurance coverage and related billing processes. I understand that I may revoke this Authorization at any time, except to the extent that the Disclosing Party has taken action in reliance on the Authorization. My revocation of this Authorization will only be effective if I submit my revocation in writing to the Disclosing Party. I understand that I am not required to sign this Authorization, and that my refusal to sign will not affect my eligibility for treatment, coverage or other benefits to which I am entitled from the Disclosing Party. I understand that information disclosed by the Disclosing Party is subject to redisclosure by the Recipient and may no longer be protected by HIPAA. I would like this Authorization to expire on written request by me to DermTech. The Disclosing Party may disclose my PHI to the Recipient pursuant to this request.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

PRINT NAME

DATE (MM/DD/YYYY)

FOR LABORATORY USE ONLY

DATE RECEIVED / / | ACCESSION ID | LIS STICKER

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