THERAMAP® Order Form

Please fax to: 888.611.6373
Email: genomics@imail.org
Questions? Call 801.441.7277

* INDICATES REQUIRED FIELD

PATIENT INFORMATION

Last Name*	First Name*	M.I.

MRN*	Date of Birth* ___/___/_____ MM / DD / YYYY	Ethnicity

Street Address 1*	Street Address 2

City	State	Zip Code

Study ID	Phone ( ) -	Sex* ☐ Male ☐ Female

SPECIMEN INFORMATION

Diagnosis/ICD10 Code*	Stage

Specimen ID	Alternate Specimen ID	Date of Collection ___/___/_____ MM / DD / YYYY

Primary Site*	Histopathology*

PATHOLOGY INFORMATION

Pathology Lab Name*	Pathology Lab Phone ( ) -

ORDERING PHYSICIAN/PROVIDER INFORMATION

Name*	Physician NPI	Institution/Office/Practice Name

Institution/Office/Practice Phone ( ) -	Institution/Office/Practice Fax ( ) -	Street Address	City	State	Zip Code

Additional Copies to

ORDERED TESTING

☐ TheraMap: Solid Tumor Panel
☐ TheraMap: Solid Tumor with Reflex
☐ TheraMap: Myeloid Malignancies (PD-L1 testing is not an option with this panel)

ADDITIONAL TESTING

☐ PD-L1 by IHC – SP142
☐ PD-L1 by IHC – SP263
(PD-L1 is not available with myeloid panel)

CLINICAL INFORMATION

Is this patient on hospice or planning to enter hospice before testing is complete?
☐ Yes ☐ No ☐ Don't Know

Please Include:
☐ Copy of Insurance Card(s)* ☐ Pathology Report*
☐ Previous NGS Report (if applicable) ☐ Medical Records

Previous Treatment:
☐ Prior NGS Testing ☐ Surgery
☐ Chemotherapy ☐ Radiotherapy
☐ Targeted Therapy ☐ Immunotherapy

Current Treatment:
☐ Not Started ☐ Surgery
☐ Chemotherapy ☐ Radiotherapy
☐ Targeted Therapy ☐ Immunotherapy

BILLING INFORMATION (PLEASE ATTACH FRONT AND BACK OF INSURANCE CARD(S))

Billing Method*:
☐ Insurance ☐ Medicare ☐ Hospital/Institution ☐ Self-pay

Specimen Collection as*:
☐ Inpatient ☐ Outpatient ☐ Outreach (non-hospital)

PRIMARY INSURANCE (IF CARD IS ATTACHED, ONLY INSURED DOB IS REQUIRED)

Primary Insurance*	Policy #*
Policy Holder*	Relationship to Patient*
Policy Holder Date of Birth* ___/___/_____ MM / DD / YYYY	Claims Address*

SECONDARY INSURANCE

Secondary Insurance	Policy #
Policy Holder	Relationship to Patient
Policy Holder Date of Birth ___/___/_____ MM / DD / YYYY	Claims Address

COMMENTS

Comments	Physician Signature*	Date* ___/___/_____ MM / DD / YYYY

Statement of Medical Necessity/Consent

"I hereby order Intermountain Precision Genomics to conduct the above test(s) and furnish the TheraMap® service(s), which I have determined to be medically necessary. The medical necessity of the above test(s) and service(s), including navigation services, have been adequately documented in the patient's medical record. I have explained the risks, benefits and limitations of the above test(s) and service(s) to this patient, and have received informed consent from the patient, to the extent legally required, to permit Intermountain Precision Genomics to (i) perform the test(s) and service(s) specified herein, (ii) retain the test results for an indefinite period for internal quality/operations purposes, (iii) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (iv) release the test results to the patient's third-party payer as needed for reimbursement purposes. I agree to provide Intermountain Precision Genomics with the information and documentation needed for Intermountain Precision Genomics to bill and collect for the above test(s) and service(s)."

Please see next page for sample specifications and shipping.