HepatoTrack® for Liver Transplant

Test Requisition Form

FAX to (858) 377-6003

Please place collection kit barcode here.

I. Patient Information

First Name *	Last Name *	Middle Name
Date of Birth *	Biological Sex * ☐ Male ☐ Female	Unique Patient Identifier (e.g., MRN)
Address *	City *	State *
Zip *	Phone # *	Email

II. Clinician Information

Clinic or Transplant Center *	
Ordering Physician *	NPI # *
Practice Address	

Phone	Fax	Primary Contact

III. Healthcare Provider Authorization

By signing below, I, the healthcare provider, acknowledge that the HepatoTrack test is medically necessary for the clinical management of the patient, and that I have evaluated its risk/benefit profile. I confirm that the patient has been informed of the details of the test, including risks, benefits, and alternatives, and has consented to testing as required by applicable law, including NY CVR §79-l. I attest that all necessary authorizations have been obtained from the patient to release medical and insurance information for processing claims, and to assign the right to receive payment to LuminoDx. Additionally, I authorize the performance of the test and affirm that the procedures and their purpose have been explained to the patient. I also confirm that the test results will be used to guide clinical decisions, including potential changes to the patient's medication, and that I have made an informed decision based on the patient's medical history. Finally, I have informed the patient that LuminoDx may be an out-of-network provider under their insurance plan and that I have no financial interest in LuminoDx.

Healthcare Provider Signature *	Date *

IV. Patient Healthcare Information

Sample Collection Date *	Order Type * ☐ Initial Order ☐ Recurring Order
Transplant Date *	Donor Type * ☐ Living ☐ Deceased
Donor Relationship * ☐ No biological relationship ☐ Related, relationship is _____	
Reason for Ordering Test * ☐ For cause testing to inform biopsy decision ☐ Surveillance testing (protocol biopsy monitoring) ☐ OTHER: _____	ICD10 Code * ☐ Z94.4 (Liver transplant status) ☐ T86.40 (Unspecified complication of liver transplant) ☐ Other: _____

V. Patient Healthcare Information

Payment option * ☐ Private insurance ☐ Medicare ☐ Medicaid ☐ Self-Pay ☐ Client Sponsored		
For private insurance, please provide front/back copy of insurance card *		
Primary Insurance Provider *	Subscriber ID *	Group ID *
Secondary Insurance Provider	Subscriber ID	Group ID