Silbiotech, Inc.

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BBDRisk Dx**®**

Test Request Form

Section 7. Pathology Information

Collection Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen Type: □ FFPE Block □ FFPE Slides □ Right Breast □ Left Breast

Submitting Diagnosis (check all that apply): □ ADH □ ALH □ UDH □ ULH □ PAPILLOMA □ Sclerosing Adenosis

**Please include Pathology Report with the Test Request Form and an H& E slide from the selected block(s)**

Section 6. Specimen Information

Complete the following and attach a copy of front and back of insurance card

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Type: □ Private Insurance □ Medicare □ Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Name Member ID

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Authorization # (if available) Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Name Member ID

Relationship to Insured: □ self (skip section below) □ Spouse □ Dependent

Other: Insured DOB \_\_\_\_\_\_\_\_\_\_\_\_ Insured SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: Last First Middle

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Country

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Patient Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record# SSN

Practice Account Details:

Address Breast Center:

City: State: Zip code:

Phone: Fax:

Ordering Physician Name:

Contact Name:

Contact Phone:

Contact email:

Send Report by: Mail □ Fax □ email □



**SILBIOTECH, INC.**

Practice Account Details:

Address:

Phone: Fax:

Submitting Pathologist Name:

Block Return Location (If different):

Phone:

Contact Name:

Specimen ID(s):

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Surgery Date Pulled from Archives

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments

Section 4. Patient Information Section 5. Billing Information

Section 5

I represent that I am treating this patient as the physician of record and authorizing the performance of the test identified on this order. I have concluded that the test I am ordering is medically necessary for treatment of this patient. I anticipate that the test will provide predictive information which has not been obtained already. This order form is part of the medical record, is consistent with other entries in the record and accurately describes the reason I am ordering the test. In submitting this order, I acknowledge that I have obtained the consent from the patient for Silbiotech, Inc. to release the test results to the patient’s third party payer when necessary as part of the reimbursement process. I have read and agree to be bound by Silbiotech, Inc.’s general terms and conditions.

Ordering Physician Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 2. Physician Information Section 3. Physician Signature

□ First Submission □ Resubmission-Associated Requisition #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 1. Submission Status