



## APERIOMICS *Xplore-Patho*® TEST ORDER FORM

**PATIENT INFORMATION AND ACKNOWLEDGEMENT:**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
 Street address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_  
 Cell:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

*I authorize Aperiomics, Inc to test my sample(s). Aperiomics does not provide diagnosis, treatment, or medical guidance. Aperiomics provides information to be used by healthcare providers as a resource in determining their independent diagnosis and/or treatment plan. I have fully reviewed this form, understand, and agree to its terms. I understand that this test may not be covered by insurance if it falls outside of my insurance carrier's medical and coverage guidelines. I accept full financial responsibility for the pre-payment of testing as indicated on this form.*

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*\* Once your invoice is paid, you will receive your collection kit(s) in the mail. When Aperiomics receives your samples back, all forms must be completed in full, and your healthcare provider must have signed the requisition form and entered appropriate ICD-10 codes. Failure to have all forms completed will result in your sample(s) processing being delayed. By initialing below, I affirm that I have read and understand that I need a qualified healthcare provider to sign the requisition form for this testing service and for my samples to be processed.*

initial here: \_\_\_\_\_

**PATIENT BILLING INFORMATION:**

Bill Method: Credit Card:  HSA/ FSA:   
 Billing address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_  
 Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_/\_\_\_\_ Security Code: \_\_\_\_  
 Name on Credit Card: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CLINICIAN INFORMATION:** *(Required for US Residents, Requested for Everyone)*

Clinic/ Clinician's Business Name: \_\_\_\_\_  
 Ordering Clinician's Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ *(not required)* Clinician's Business Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

***Xplore-Patho*® SAMPLE KIT MENU:**

Blood Plasma <input type="checkbox"/>	Swab <input type="checkbox"/> Site: _____
Fecal <input type="checkbox"/>	Urine <input type="checkbox"/>
Tissue <input type="checkbox"/> Type: _____	Cerebral Spinal Fluid <input type="checkbox"/>
Sputum <input type="checkbox"/>	Expressed Prostate Secretion <input type="checkbox"/>

**\* Please email the completed copy of this form to [orders@aperiomics.com](mailto:orders@aperiomics.com)**

**INSURANCE REIMBURSEMENT POLICY**

Although Aperiomics is not accepting insurance at this time, we are currently out of network with 3 private insurance providers:

**UnitedHealthcare, Blue Cross Blue Shield, and Cigna**

Some patients are receiving, on average, 65 - 85% reimbursement for the Aperiomics' *Xplore-Patho*<sup>®</sup> test with the insurance providers listed above.

***Xplore-Patho*<sup>®</sup> CPT Billing Codes** (for insurance reimbursement):

89240, 81479, 87153, 81406, 89240

***Xplore-Patho*<sup>®</sup> PATIENT PRICING TABLE**

	<b><i>United States</i></b>	<b><i>International</i></b>
<b><i>Per Sample Kit Ordered</i></b>	\$750 per DNA Sample \$1050 per RNA Sample	\$750 per DNA Sample \$1050 per RNA Sample + 200 International Shipping

Number of Collection Kits Ordered: \_\_\_\_\_ International Shipping:  Yes  No

**\* Please email the completed copy of this form to [orders@aperiomics.com](mailto:orders@aperiomics.com)**