COLOSENSE TEST REQUISITION AND STATEMENT OF MEDICAL NECESSITY

Stool-based RNA test with hemoglobin immunoassay component

GENEOSCOPY, INC.
2220 Welsch Industrial Ct., St. Louis, MO 63146
(800) 305-8299 | Geneoscopy.com
NPI: 1245996750 CLIA: 26D2253457

Ordering Instructions

1. Complete all required sections below.
2. Ordering Provider MUST sign and date this form.
3. Include patient demographic face sheet (preferred) and/or a copy of the Patient's insurance card (front & back). Demographic sheet should include the Patient's name, DOB, address, mobile number and insurance information.
4. Fax completed ColoSense order requisition form and billing documents to **(314) 408-3864.**

Provider & Order Information

PROVIDER INFORMATION (REQUIRED)

Provider Name **(First Name, Last Name):** _____

Healthcare Organization Name: _____ NPI Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ *Secure Fax Number: _____

***Result will be provided to the secure Fax number above.**

ORDER INFORMATION (REQUIRED)

ICD-10 Code:

The following ICD-10 codes are provided for your convenience only. This section is not intended to influence your medical judgment in determining whether this test is appropriate for the particular patient. Select the diagnosis code(s) that best describe(s) the reason for ordering this test.

☐ **Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])**

☐ **Other Code:** _____

Certification

I am a licensed healthcare provider authorized to order ColoSense. This test is medically necessary and the Patient is eligible to use ColoSense. I confirm that the Patient is asymptomatic, at the average risk of developing Colorectal Cancer (CRC), and has not been screened by another CRC screening method within the past year. I agree to provide a copy of relevant clinical history and medical records in order to support a request from a health plan. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Geneoscopy, Inc. to obtain reimbursement for ColoSense and to directly contact and collect additional samples from the Patient as appropriate.

Ordering Provider Signature: _____ **Date:** _____

Patient Contact & Billing Information

PATIENT INFORMATION (REQUIRED)

Patient Name **(First Name, Last Name):** _____

Date of Birth **(mm/dd/yyyy):** _____ Sex: ☐ **Male** ☐ **Female** ☐ **Not Given**

Patient Email: _____ Mobile Number: _____

☐ **By checking this box, I confirm that the Patient has consented to receive calls and/or text messages from Geneoscopy regarding general Colorectal Cancer (CRC) screening updates, reminders, and personal account details. The Patient accepts that message frequency may vary and data rates may apply. It has been communicated to the Patient that they may text "Help" for Help. See Terms & Conditions at geneoscopy.com/sms and Privacy Policy at geneoscopy.com/privacy-policy.**

NOTE: If this box is not checked, Geneoscopy will still be able to provide reminders / notifications to patient via phone call or text message about their current ColoSense order or test results. If patient wishes to receive no communications, they may contact 1-800-305-8299 to update their preferences.

Language Preference: ☐ **English** ☐ **Spanish** ☐ **Other:** _____

PATIENT ADDRESS (REQUIRED)

Address: _____

City: _____ State: _____ Zip: _____

PATIENT ETHNICITY AND RACE (OPTIONAL)

Is your Patient of Hispanic or Latino origin or descent? ☐ **Yes** ☐ **No**

Please mark one to indicate the Patient's race:

☐ **White** ☐ **Black or African American** ☐ **Asian** ☐ **Native Hawaiian or other Pacific Islander** ☐ **American Indian or Alaska Native** ☐ **Other**

Fax completed form to (314) 408-3864

©2026 Geneoscopy, Inc.