Proteocyte AI
Designing tests that predict your risk of developing cancer

Test Request Form
Getting Started

Straticyte™
Predicting Your Risk Of Developing Oral Cancer

FAX COMPLETED FORMS & CHART NOTES TO: 1-888-521-1073

QUESTIONS?

Call: 1-833-5-PROTEO (1-833-577-6836)

Email: proteocyte@patientcaresolutions.com

☐ **STEP 1** Complete patient consent and Test Request Form (TRF). Compile supporting documents for Proteocyte to respond to additional documentation requests (ADRs) from payors.	☐ **STEP 2** Fax all forms AND any of the clinical documentation and/or chart notes to support medical necessity	☐ **STEP 3** Let your patient know you are sending in a test request form for them & Proteocyte may reach out if needed
• Patient and/or caregiver read and sign the consent form • HCP requesting Straticyte to complete and sign the consent form • Complete entire patient TRF • Patient face sheet/demographic sheet • Copy of insurance cards and/or billing/payment information • Compile relevant documents that will help ensure patient's insurance covers the requested test • Documents must indicate why Straticyte is medically necessary and the patient's diagnosis of Oral Potentially Malignant Disorder (OPMD), or oral pre-cancer	• Relevant chart notes documenting OPMD • Documentation of Dx (ICD-10) code: K13.21, K13.29, K13.79, or other • Biopsy type (incision/excision) • Biopsy site(s) • Images of lesions (strongly recommended) • Pathology report of biopsy specimen(s) • History of any other types of cancer(s), risk for cancer, or relevant clinical information • Information about Straticyte test and why it is medically necessary/urgently needed	• Some patient insurance companies may pend claims submitted for Straticyte post test completion • If patients' insurance requires additional documentation, the information submitted will be leveraged first to support medical necessity • Informing your patient and/or caregiver as to why Straticyte is being performed, in addition to routine histopathologic examination is critical in the event their insurance company calls them directly • Provide your patient with information on Straticyte and the benefit of the test to help better asses the 5-year probability of an OPMD transforming into oral cancer

Proteocyte AI
Designing tests that predict your risk of developing cancer

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

Straticyte™
Predicting Your Risk Of Developing Oral Cancer

PATIENT INFORMATION

COMPLETE the following or attach copy of face sheet/demographic sheet

Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)	Sex at Birth ☐ Female ☐ Male ☐ Decline to Answer	Last 4 digits of SSN
Address	City	
	State	Zip Code
Preferred Phone #	Preferred Email	
Caregiver Name	Relationship to Patient	
Caregiver Phone #	Caregiver Email	

PRIMARY BILLING / PAYMENT INFORMATION

COMPLETE the following or attach a copy of front and back of insurance cards (if applicable)

PAYOR TYPE	☐ Patient ☐ Commercial ☐ Medicare FFS ☐ Medicare Adv ☐ Medicaid FFS ☐ Managed Medicaid
Plan Name	Plan Phone
Plan Type ☐ HMO ☐ PPO ☐ POS ☐ HDHP ☐ Other	Plan Fax
Policy Holder Name	Date of Birth (mm/dd/yyyy)
Member ID	Group ID
Dental Insurance Plan	Dental Phone

SECONDARY PATIENT INSURANCE INFORMATION (IF APPLICABLE)

COMPLETE the following or attach a copy of front and back of insurance cards (if applicable)

PAYOR TYPE	☐ Patient ☐ Commercial ☐ Medicare FFS ☐ Medicare Adv ☐ Medicaid FFS ☐ Managed Medicaid
Plan Name	Plan Phone
Plan Type ☐ HMO ☐ PPO ☐ POS ☐ HDHP ☐ Other	Plan Fax
Policy Holder Name	Date of Birth (mm/dd/yyyy)
Member ID	Group ID
Coordination of Benefits (if known)	

Phone: 1-833-5-PROTEO (1-833-577-6836)
Fax: 1-888-521-1073
Email: proteocyte@patientcaresolutions.com

Proteocyte AI
Designing tests that predict your risk of developing cancer

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

Straticyte™
Predicting Your Risk Of Developing Oral Cancer

CLINICAL INFORMATION

ICD-10	**Biopsy Date (mm/dd/yyyy)**	**Biopsy Site**
☐ K13.21 Leukoplakia of oral mucosa, including tongue ☐ K13.29 Other disturbances of oral epithelium, including tongue ☐ K13.79 Other lesions of oral mucosa ☐ Other: _____	**Biopsy Type** ☐ Excision ☐ Incision	☐ Lip ☐ Buccal Mucosa ☐ Floor of Mouth ☐ Tongue ☐ Other _____

Final Diagnosis of Biopsy		
3-tier	**2-tier**	**Notes & Concerns**
☐ No dysplasia ☐ Mild dysplasia ☐ Moderate dysplasia ☐ Severe dysplasia	☐ Low-grade dysplasia ☐ High-grade dysplasia	

SPECIMEN INFORMATION & RETRIEVAL

Surgical Specimen/Accession #	☐ Corresponding Pathology Report Attached

ORDERING CLINICIAN

Site Name	Site Phone	
	Site Fax	
Address	City	
	State	Zip Code
Site Contact Name	Role	
Site Contact Phone	Site Contact Fax	
Site Type ☐ MDO ☐ HOPD ☐ ASC ☐ Dentist ☐ Lab ☐ Other _____	Health System	
Provider Name	NPI	
Provider Specialty	State License #	TIN#
Medicaid Provider ID #	Medicare PTAN	

Phone: 1-833-5-PROTEO (1-833-577-6836)
Fax: 1-888-521-1073
Email: proteocyte@patientcaresolutions.com

Proteocyte AI
Designing tests that predict your risk of developing cancer

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

Straticyte™
Predicting Your Risk Of Developing Oral Cancer

LAB TEST ORDERED: STRATICYTE™

Straticyte – uses a probability algorithm developed from an annotated cohort of reference cases to assess the 5-year probability of an oral potentially malignant lesion transforming to oral squamous cell carcinoma. It provides supplemental information for the corresponding pathology report. This test is not appropriate for lesions diagnosed as carcinoma.

ORDERING CLINICIAN SIGNATURE

I hereby authorize testing and confirm that informed consent has been obtained from the patient for relevant information to be sent to Proteocyte AI for testing. I hereby attest as the ordering clinician that I am authorized by law in the relevant jurisdiction to order the test requested herein. By signing this form, I attest that the patient meets the inclusion criteria stated in the test ordered section, and the clinical information described on this form is correct and belongs to the patient named. I have had a discussion prior to testing regarding how the results of the test may be used to guide patient management.

Ordering Clinician Signature	Date (mm/dd/yyyy)

PATIENT CONSENT AND/OR AUTHORIZED SIGNATORY

I understand that my tissue sample provided to the pathologist from my biopsy will be collected, transported, and delivered to Proteocyte AI to assess my probability of an oral potentially malignant lesion transforming to oral squamous cell carcinoma, providing supplemental information for my corresponding pathology report. I have been informed by my treating clinician about the purpose, scope, and limitations of the test ordered. I understand that the results of the test will be sent or made available to my treating clinician, and when the results are ready, I will collect the information from my treating clinician. I am informed of who may have access to my sample and test results, which includes confidential protected health information (PHI). I understand that my PHI will be securely handled by PatientCare Solutions, Inc., a third-party vendor working in association with Proteocyte AI for data processing, billing, reimbursement, and administration of services. I hereby give consent to such processing and storage of my PHI and may revoke this consent at any time. I have read this form and I agree to undergo the test. I confirm I have had the opportunity to ask any questions that I might have had regarding this test and process and have received satisfactory answers from my treating clinician.

Patient Signature	Date (mm/dd/yyyy)

Phone: 1-833-5-PROTEO (1-833-577-6836)
Fax: 1-888-521-1073
Email: proteocyte@patientcaresolutions.com