REPLY FORM

Please return this form with the InSure® Test Card

InSure® FIT™
Fecal Immunochemical Test

Immunoassay for Human Hemoglobin in Stool

DO NOT SEND COMPLETED TEST CARDS TO QUEST DIAGNOSTICS OR ENTERIX

LIMITATIONS OF THIS TEST

- This test detects human blood on or in your stool. There are many colorectal conditions, such as polyps, colitis, diverticulitis, hemorrhoids, fissures or colorectal cancer that may cause blood in your stool. If you receive a "positive" test result, more testing and evaluation by a doctor is necessary. This additional testing and evaluation may include diagnostic tests that might help your physician understand the cause of the blood in your stool.
- This test does not replace your regular physical or rectal examination by your doctor.
- A "negative" test result means that no human blood was found in the samples. However colorectal lesions, including some polyps and colorectal cancers, may bleed intermittently, or not at all. Additionally, blood may not be uniformly distributed in or on stool and a test may result may be negative even when blood or a lower gastrointestinal disease is present. Therefore, independent medical authorities such as the American Cancer Society recommend that healthy adults age 50 and older have a fecal occult blood test each year. If you become ill, or have symptoms of colorectal disease, you should see your doctor.
- If you do not follow the test instructions, you may collect one or more insufficient samples and get a wrong test result.
- Your samples are perishable. If your Test Card is not received within 14 days of collection of the first sample, it will not be tested.
- Use this kit before the Expiration Date printed on the Test Card enclosed.

If you have any questions or need help using InSure®, please contact your physician.

PATIENT INFORMATION

***To be completed by patient.* PLEASE PRINT CLEARLY.**
All information is necessary for test processing and will be kept confidential.

Last Name _____ First Name _____ MI ____ Patient Date of Birth ____/____/____

☐ Male ☐ Female ( ) Daytime Phone _____ ( ) Evening Phone _____

Mailing Address _____ City _____ State ____ Zip Code _____

SAMPLE INFORMATION

IMPORTANT: ***We cannot process your test without accurate sample dates.***

Date of Sample 1 Bowel Movement ____/____/____ (MM / DD / YYYY)

Date of Sample 2 Bowel Movement ____/____/____ (MM / DD / YYYY)

BILLING INFORMATION

PLEASE PRINT CLEARLY. ***This information must be complete or results may be delayed. Your insurance company will be billed. Patient/responsible party is financially responsible for any portion of the claim not covered by your insurance company.***

Please provide all required insurance information below and complete the field in its entirety to avoid receiving a bill.
Only list your primary insurance. DO NOT LIST SUPPLEMENTAL INSURANCE.

I do not have insurance so please bill me directly for services: (please check) _____

Fill out **#1** if your primary insurance is **Medicare**; Fill out **#2** if your primary insurance is **Medicaid**; Fill out **#3** if your primary insurance coverage is something **other than** Medicare or Medicaid.

1. If your primary coverage is **Medicare,** list entire Medicare number: |__|__|__|__|__|__|__|__|__|__|__|__|
STOP: Additional information is not necessary.

2. If your primary coverage is **Medicaid,** list entire Medicaid number: _____
STOP: Additional information is not necessary.

3. If your primary coverage is insurance **other than** Medicare or Medicaid, please fill out the information below:

Subscriber Name _____ Employer Name _____

Insurance Company Name _____ Insurance Company Phone: _____

Insurance Company Claim Address _____ City _____ State ____ Zip Code _____

Member ID / Subscriber Number _____ Group Number (if applicable) _____

Relation to Patient: Self_____ Spouse_____ Other_____

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