HeartCare™ Test Requisition Form

PLACE ACCESSION LABEL HERE

All items highlighted in blue are required. Missing information may delay testing.

Ordering Clinician: Complete all required sections and sign the requisition.
Phlebotomists and AlloMap Processors: Complete blue boxes to the right.
Lab: Follow accession labeling instructions in collection kit. Add label to top-right corner of this form.
Report Delivery: Via caredxportal.com. Copies available via fax, EMR, and other secure methods.
For help finding a draw center or additional assistance, call (888) 255-6627 or email CustomerCare@CareDx.com

Collection Facility Name		
Collection Date	Collection Time ☐AM ☐PM	Phleb Initials
AlloMap Processing Facility Name		
AlloMap in Freezer Time ☐AM ☐PM	AlloMap Processor Initials	

Patient Information

Patient Last Name		Patient First Name	MI	Unique Patient Identifier (e.g., MRN)	
DOB (mm/dd/yyyy)	Patient Sex ☐ Male ☐ Female	Patient Primary Phone	Patient Email		
Patient Address		City	State	Zip	☐ Check box if patient is pregnant

Patient Insurance Information

Primary Insurance	Member ID #	Subscriber Name (if different from patient)
Secondary Insurance (if applicable)	Member ID #	Subscriber Name (if different from patient)

Bill to Facility: ☐ Check if patient has Medicare insurance and test was ordered inpatient, or patient coverage is under private insurance case rate.
In such cases, the hospital may be billed for the test.

Test Requested

Reason for Requesting Test (choose one) ☐ **Stable Cardiac Function** (ICD-10 Z94.1) ☐ **Unstable Cardiac Function** (ICD-10 Z94.1)
Test Requested (choose one) ☐ HeartCare (AlloMap & AlloSure) ☐ AlloMap Heart ☐ AlloSure Heart ☐ AlloSure Heart

For patients beyond year 3 post-transplant: Select any factor that elevates the patient's risk of sub-clinical rejection and warrants extended surveillance testing (choose one)

☐ Reduced immunosuppression (including calcineurin free immunosuppression, subtherapeutic levels, non-adherence)
☐ History of recurrent acute rejection
☐ Known DSA
☐ Chronic graft dysfunction
☐ New sign or symptom of uncertain significance
☐ N/A
☐ Other: _____

Clinical Information

Active Transplant Date (mm/dd/yyyy)

Study Participant ID (if applicable)

Other Transplant Organs: Check box if other transplant(s) are present in patient and specify, including allogeneic bone marrow transplant.
☐ Organ(s) (specify) _____
Transplant Date(s) _____
If multiorgan, choose one: ☐ Same Donor ☐ Different Donor

Additional ICD-10 Codes (if applicable)
☐ Z48.21 - Encounter for aftercare following heart transplant
☐ T86.20 - Unspecified complication of heart transplant
☐ Z48.288 - Encounter for aftercare following multiple organ transplant
☐ Other: _____

Order Schedule: Choose one option. Order expires 12 months from order date.
☐ Heart Testing Schedule Post-Transplant: Year 1 Monthly; Years 2&3 Quarterly; Years 4+ Biannually
☐ Custom Order (complete section to the right)
☐ Single Order
For changes to the order, please call CareDx at (888) 255-6627 or email CustomerCare@CareDx.com

Custom Order Schedule

☐ Jan	☐ May	☐ Sep
☐ Feb	☐ Jun	☐ Oct
☐ Mar	☐ Jul	☐ Nov
☐ Apr	☐ Aug	☐ Dec

Expected Date(s) (mm/dd/yyyy)
_____
_____

Additional Information (Donor is assumed to be unrelated, please note if not.)

_____

Ordering Clinician Information

Ordering Clinician	NPI	Clinician Address	
Clinic/Institution	Contact Name		Phone

Statement of Medical Necessity Acknowledgment: Your signature constitutes a statement of medical necessity and your attestation that the test was ordered after evaluating its risk/benefit profile, to assist in the evaluation of the transplanted organ for active rejection, is reasonable and medically necessary, and will be used in the clinical management of the patient. Your signature on this form also indicates that the clinician or clinician's delegate has obtained all necessary 1) authorizations from the patient, including informed consent as to the nature of testing, 2) authorizations to release any medical and insurance information to process claims for services provided by CareDx, Inc., and 3) authorizations from patient to assign billing and reimbursement of insurance claims directly to CareDx, Inc. for services rendered.

Authorized Ordering Clinician Signature: _____ **Date:** _____

CareDx Inc. 3260 Bayshore Blvd., Brisbane, California 94005 | P: (888) 255-6627 F: (415) 287-2456 CustomerCare@CareDx.com www.CareDx.com

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