

Test Requisition Form

1. Client Information:

Ordering Physician:

NPI:

Client Information:

2. Molecular Diagnostics Test Offering: (REQUIRED)

☐ I confirm this order is for a patient being considered for repeat biopsy due to persistent or elevated cancer-risk factors.



3. Patient Information:

Name (first/middle/last): _____ Phone: _____

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

Date of Birth: _____ Social Security #: _____ Medical Record/Patient ID: _____

Month Day Year

4. Clinical Information: (Required)

Date of Last DRE: _____ Last DRE: ☐ Suspicious for Prostate Cancer ☐ Not Suspicious for Prostate Cancer

Month Day Year

Date of Last PSA: _____ Last PSA: _____ ng/mL Prostate Volume: _____ Has this patient been treated with 5ARI? ☐ Yes ☐ No

Month Day Year

5. Specimen Information: (Please provide a copy of pathology report, history & physical, and office/progress notes with test order)

Collection Date: _____ Date Retrieved from Archive: _____ Specimen ID(s): _____

Month Day Year

Month Day Year

Fixative type if other than formalin: _____ Microns per slide # _____ Slides # _____ Blocks # _____ (Blocks may be exhausted and/or re-embedded)

6. Required Billing Information: (Please provide a copy of the front and back of the insurance card)

ICD-10 Codes: ☐ D29.1 Benign neoplasm of prostate ☐ R97.20 Elevated prostate specific antigen [PSA] ☐ N40.0 Enlarged prostate without lower urinary tract symptoms

☐ N40.1 Enlarged prostate with lower urinary tract symptoms ☐ N40.2 Nodular prostate without lower urinary tract symptoms

☐ D40.0 Neoplasm of uncertain behavior of prostate ☐ Other: _____

Required Information/Patient Status: ☐ Hospital Inpatient & Date of Discharge: _____ ☐ Hospital Outpatient

Payment Type: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Patient Self-Pay ☐ Client (contract required)

PRIMARY INSURANCE: ☐ Insurance information attached

Name of Healthplan: _____ Insured Name: _____

Subscriber ID#: _____ Group#: _____ Authorization#: _____

Billing Address: _____ Phone: _____

PLEASE ATTACH SECONDARY INSURANCE

7. ConfirmMDx Specimen Request:

☐ Obtain formalin-fixed paraffin-embedded tissue blocks or unstained slides (40µm each body site) Facility: _____

Contact Name/Department: _____ Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

8. Additional Notes:

9. Authorization:

Authorized Signature (No stamped signatures please) _____

Date _____

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I confirm that this is medically necessary and the results will be used in the medical management decisions for the patient. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test requested herein. I confirm that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers, such as MDxHealth, Inc. I authorize MDxHealth to release the information on this form, and other information provided by me, necessary to process a claim for this service.

For Medicare Beneficiaries: I further certify that this patient is being considered for repeat biopsy due to persistent or elevated cancer-risk factors.

PLEASE DETACH YELLOW COPY AND RETAIN IN PATIENT'S MEDICAL RECORD

MDxHealth Internal Use Only: Total pages _____ Blocks _____ Slides _____