MDxHealth®

Test Requisition Form

1. Client Information:

Ordering Physician: NPI:

Client information:

2. Molecular Diagnostics: (You must check one box)

Specimen type: Tissue

☐ ConfirmMDx for Prostate Cancer — DRE result, DRE date, PSA result, and PSA date are required for testing.

Specimen type: Urine

☐ SelectMDx for Prostate Cancer — First void post-DRE urine, DRE result, DRE date, PSA, and PSA date are required for testing.

3. Patient Information:

Name: (First)________ (Middle)________ (Last)________ Phone: ( ) -

Address:________ City:________ State:____ Zip:____

Date of Birth: Month — Day — Year Social Security #: ___ — __ — ____ Medical Record/Patient ID:________

4. REQUIRED Clinical Information for Reimbursement:

ICD-10 Codes: ☐ D29.1 Benign Neoplasm of Prostate ☐ R97.2 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:________

Biopsy History: ☐ 1st Biopsy ☐ 2nd Biopsy ☐ 3rd Biopsy ☐ 4th Biopsy ☐ Other:________

Histopathology Findings: ☐ Benign ☐ HGPIN ☐ PIA ☐ Other:________

Date of Last DRE: Month — Day — Year Last DRE: ☐ Normal ☐ Abnormal Date of Last PSA: Month — Day — Year Last PSA:_____ng/mL

Has the patient been treated with 5ARI? ☐ Yes ☐ No Prostate Volume:____ Family History:____ Race:____ %Free PSA:____

5. Specimen Information: (Please provide a copy of pathology report, History & Physical and office/progress notes including test order)

Collection Date: Month — Day — Year Date Retrieved from Archive: Month — Day — Year Specimen ID(s):________

Fixative type other than formalin:________ ☐ Microns per slide #____ ☐ Blocks #____ ☐ Slides #____ ☐ Permission to exhaust blocks if necessary

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

Required Information/Patient Status: ☐ Non-Hospital Patient ☐ Hospital Inpatient & Date of Discharge:________ ☐ Hospital Outpatient

☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Patient Self-Pay ☐ Client (contract required) ☐ Study/Protocol:________

PRIMARY INSURANCE: ☐ Insurance information attached

Name of Healthplan:________

Insured Name:________

Subscriber ID#:________

Group#:________ Authorization#:________

Billing Address:________

Phone: ( ) -

RELATIONSHIP TO INSURED:

☐ Self ☐ Spouse ☐ Dependant ☐ Other:

Insured DOB: Month — Day — Year

Insured SS#: ___ — __ — ____

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 stampled signatures please)* Date ___/___/___

Submitting this form constitutes a Certification of Medical Necessity and a certification that you have obtained consent for MDxHealth Inc. to release the test results and relevant medical information to the patient's insurance carrier as part of the coverage and reimbursement process.

MDxHealth Internal Use Only: Total pages____ Blocks____ Slides____ Tubes____

For SelectMDx Only

(If available)

Place Patient Label Here

(Bar code provided in the SelectMDx Urine Collection Kit)

Place Provided Bar Code Here

Two bar codes are provided in the SelectMDx Urine Collection kit. One bar code is required to be labeled with the patients name and date of birth and adhered to the urine specimen tube, the second label is to be placed here.

MDxHealth Inc.
15279 Alton Parkway | Suite 100 | Irvine, CA 92618 | Toll Free: 866.259.5644 | P: 949.812.6979 | F: 949.788.0014 | E: clientservices@mdxhealth.com | www.mdxhealth.com

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(A) Notifier(s):

(B) Patient Name: **(C) Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for **(D)**_____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **(D)**_____________ below.

(D) ________________________	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **(D)**____________listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **(D)**_________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **(D)**_________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **(D)**_________listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (07/10) Form Approved OMB No. 0938-0566

Please fax or send this completed form along with a copy of your insurance card(s) to:

MDxHealth
15279 Alton Parkway Suite 100
Irvine, CA 92618
Ph: 866-259-5644
Fax: 949-271-4716

Assignment Of Benefits, Authorization Release Form

Patient Name: ______________________________

Patient Address: ______________________________

City: ______________ State:____ Zip:_______ Phone:__________

I hereby assign to **MDxHealth Inc.** all my right to, title and interest in and to any and all medical and/or other health care benefits payable to or for me (including without limitation Medicare and Medicaid) on account of services provided to me by **MDxHealth Inc.**, and hereby authorize payment to **MDxHealth Inc.** on account of such benefits. I hereby authorize the release to **MDxHealth Inc.** of any medical and insurance information necessary to process claims for services provided by **MDxHealth Inc**. I hereby authorize MDxHealth Inc. to pursue all necessary appeals of full or partial denials of payment in relation to services provided by **MDxHealth Inc.**

In exchange for this assignment of benefits, **MDxHealth Inc.** agrees to accept assignment of the medical and /or other health plan, insurer or other payer(s), i.e. , and shall not balance bill me for the difference between my benefits and **MDxHealth Inc.** retail charge for it's services.

I acknowledge and agree that I remain responsible for applicable co-payments, deductibles and co-insurance as required by my medical and/or other healthcare benefits plans. If I receive payment of medical and/or other health benefits on account of services provided by **MDxHealth Inc.** I shall pay **MDxHealth Inc.** the full amount of that payment.

Note To Patients: **MDxHealth Inc.** billing and reimbursement professionals will work diligently to obtain payment from your insurance company. We will do our best to minimize any patient financial burden. For further assistance please contact the **MDxHealth billing department toll free at 866-259-5644.**

X______________________________
Patient / Health Care Power Of Attorney (Signature)

X______________________________
Print Name Of Patient / Health Care Power Of Attorney

____
Power Of Attorney Relationship To Patient

_____ / _____ / _____
Month Day Year

Appointment Of Authorized Representative Form

I appoint **MDxHealth Inc.** to act on my behalf or on behalf of in connection with any claim for coverage or benefits including receipt of any approvals or authorizations that are required before medical services are rendered. I authorize **MDxHealth Inc.** to request and receive any and all information that is provided to me and to act for me and or my covered spouse or dependent if named above as the patient, in providing any information to the health plan or other payer(s) that relates to any claim for coverage or benefits under any plan of benefits.

X______________________________
Signature of Patient / Member

_____ / _____ / _____
Month Day Year

For MDxHealth Use Only

____
Name Of MDxHealth Billing & Reimbursement Representative

_____ / _____ / _____
Month Day Year