ConfirmMDx® for Prostate Cancer

Test Requisition Form

1. Client Information:

Ordering Physician: NPI:

Client Information:

2. Molecular Diagnostics: (Checking this box is required for testing)

☐ ConfirmMDx for Prostate Cancer For patients with a previous negative, HGPIN, atypia or ASAP prostate biopsy.

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. Clinical Information: (Required)

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:_____

Date of Last DRE:_____ (Month Day Year) Last DRE: ☐ Suspicious for Prostate Cancer ☐ Not Suspicious for Prostate Cancer

Date of Last PSA:_____ (Month Day Year) Last PSA:_____ng/mL Prostate Volume:_____ Has this patient been treated with 5ARI? ☐ Yes ☐ No

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

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

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)

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

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_____

MDxHealth® www.mdxhealth.com

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