Liquid Biopsy

SelectMDx® for Prostate Cancer

Test Requisition Form

1. Client Information:

Ordering Physician: NPI:

Client information:

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

☐ SelectMDx for Prostate Cancer First void post-DRE urine, DRE result, DRE date, PSA result, PSA date and **ABN/Consent Form (on back)** 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. 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:_____

Collection Date:_____ (Month / Day / Year) Specimen ID:_____

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:_____ Family History:_____

5. 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

6. Additional Notes:

_____

_____

7. 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_____ Tubes_____

(If available)

Place Patient Label Here

(Barcode provided in the SelectMDx Urine Collection Kit)

Place Provided Barcode Here

Two barcodes are provided in the SelectMDx Urine Collection kit. One barcode is required to be labeled on the urine specimen tube with the patient's name and date of birth, the second label is placed here.

MDxHealth® www.mdxhealth.com

MDxHeath Inc. I 15279 Alton Parkway Suite 100 I Irvine, CA 92618 I p: 866.259.5644 I f: 949.788.0014 I e: client.services@mdxhealth.com

IR.FORM.0145.V02

REQUIRED FOR MEDICARE PATIENTS

Notifier: MDxHealth 15279 Alton Parkway Suite 100 Irvine, CA 92618, Toll Free 866-259-5644

Patient Name: **Identification Number:**

Advance Beneficiary Notice Of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the SelectMDx® for Prostate Cancer test 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 SelectMDx for Prostate Cancer test below.

Test:	Reason Medicare May Not Pay:	Estimated Cost:
SelectMDx for Prostate Cancer test	Medicare does not pay for this test for your condition	$500.00

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 SelectMDx test 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.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the SelectMDx test 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 SelectMDx test 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 SelectMDx test listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

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.

REQUIRED FOR MEDICARE PATIENTS ▶

Signature:	Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

REQUIRED FOR NON-MEDICARE PATIENTS

NON-COVERED SERVICES CONSENT FORM

The SelectMDx test ordered by your provider may not be considered medically necessary as defined by your health insurance plan. Your insurance plan may not pay for, or will only pay a portion of, services it does not consider medically necessary or not meeting the qualifications under your policy.

If you have questions, please call MDxHealth Billing at 1-866-259-5644 including questions about our Finacial Support Program.

I want the SelectMDx test and I understand that if my health insurance plan doesn't pay, I agree to be responsible for any portion not covered by my insurance plan, up to $500. I understand that I may apply for the MDxHealth Financial Support Program and if eligible my total financial responsibility will be less than indicated above.

REQUIRED FOR NON-MEDICARE PATIENTS ▶

Signature_____ Date_____

Print name_____