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:_____ (Month Day Year) Social Security #:_____ Medical Record/Patient ID:_____

4. Clinical Information: (Required)

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)

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_____

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