Confirm MDx® for Prostate Cancer

Test Requisition Form

1. Ordering Physician, NPI: Client Information:

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

☐ Confirm MDx for Prostate Cancer I confirm this order is for a patient being considered for repeat biopsy due to one or more persistent or elevated cancer risk factors.

3. Patient Information:

Name (first/middle/last):______________________ Cell:______________________

Address:______________________ City:______________ State:______ Zip:______________

Date of Birth:______________________ (Month Day Year) Email Address:______________________ MRN/Patient ID:______________________

4. Clinical Information: (Required for testing)

Last DRE result:

☐ Suspicious

☐ Not Suspicious

Last 2 PSA results:

PSA:________ ng/mL Date:______________________ (Month Day Year)

(2nd PSA result optional)

PSA:________ ng/mL Date:______________________ (Month Day Year)

Check all that apply:

☐ PSA level increase of > 0.35 ng/mL/year if PSA level ≤ 10 ng/mL

☐ PSA doubling time of less than 3 years, when initial PSA level ≥ 4 ng/ml and other causes of rising PSA (i.e., infection, inflammation) have been ruled out for individuals whose PSA doubling occurred in less than 2 years

☐ African American race

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

Specimen ID(s): ______________________ Collection Date:______________________ (Month Day Year) Date retrieved from archive:______________________ (Month Day Year)

6. Required Billing Information: (ICD-10 and copy of insurance card required)

☐ R97.20 Elevated prostate specific antigen [PSA]

☐ D29.1 Benign neoplasm of prostate

☐ N40.0 Benign prostatic hyperplasia without lower urinary tract symptoms

☐ N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms

☐ N40.2 Nodular prostate without lower urinary tract symptoms

☐ N40.3 Nodular prostate with lower urinary tract symptoms

☐ N41.0 Acute prostatitis

☐ N41.1 Chronic prostatitis

☐ N41.9 Inflammatory disease of prostate, unspecified

☐ N42.81 Prostatodynia syndrome

☐ N42.82 Prostatosis syndrome

☐ N42.83 Cyst of prostate

☐ N42.89 Other specified disorders of prostate

☐ N42.9 Disorder of prostate, unspecified

☐ Other:______________________

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

Patient Status: ☐ Hospital Inpatient & Date of Discharge:______________________ (Month Day Year) ☐ Hospital Outpatient ☐ Hospital Non-patient

Include copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

7. ConfirmMDx Specimen Request:

☐ I want MDxHealth to request the specimen. MDxHealth will obtain the patient's prostate biopsy from the Pathology Laboratory. Fax signed requisition, pathology report, and patient's insurance to (949) 788-0014.

8. Physician Signature & Attestation:

I hereby authorize testing and confirm that an 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 further instruct MDxHealth to retain this completed test requisition as part of the patient medical record. I authorize MDxHealth to release the information on this form, and other information provided by me, or on my behalf, necessary to process a claim for this service.

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

______________________ Ordering Physician Signature *(No stamped signatures)*

____/____/____ 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.

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

MDxHealth Internal Use Only: Total pages__________ Blocks__________ Slides__________

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