Select MDx 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 — A non-invasive liquid biopsy test to improve the early detection of clinically significant cancer.

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: (Modified DRE must be performed prior to urine collection)

Collection Date:______________ (Month Day Year) Specimen ID:______________________

Last DRE: ☐ Suspicious for Prostate Cancer ☐ Not Suspicious for Prostate Cancer

Date of Last PSA:______________ (Month Day Year) Last PSA:________ ng/mL Prostate Volume:__________ *(only if obtained by MRI or ultrasound)*

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

☐ R97.20 Elevated Prostate Specific Antigen [PSA] ☐ Other:______________________

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

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

6. Authorization and Statement of Medical Necessity:

I confirm this test is medically necessary and that prior to ordering I have confirmed that the patient meets all of the following conditions:
- Able to tolerate a prostate biopsy
- Able to tolerate treatment (either medical or surgical) for prostate cancer for Gleason Grade 2 or higher
- Considering receiving treatment for prostate cancer if found
- Has received a digital rectal procedure prior to obtaining urine in accordance with MDxHealth's instructions for obtaining a urine sample

I confirm that the results will be used in medical management of the patient, including in deciding whether or not to pursue a biopsy. I hereby authorize testing and attest that the person listed in the Physician Signature space below 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. 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: *Prior to ordering, I have confirmed that the patient presents with Elevated Prostate Specific Antigen (PSA – ICD-10 Code R97.20) with a PSA ≥ 3.*

______________________________ Authorized Signature *(No stamped signatures please)*

____/____/____ Date

Submitting this form constitutes a Certification of Medical Necessity and a certification that I 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.

(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 Internal Use Only: Total pages__________ Tubes__________

MDxHealth www.mdxhealth.com

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