Resolve mdx

UTI and STI Test Requisition Form

Ordering Physician

Account Information

Patient Information

Name: *First* *Last*

Address:

City: State: Zip:

Email Address: Phone:

Date of Birth: Month Day Year Sex: M F MRN/Patient ID:

1. Select Test(s)

Checking box(es) required for testing.

☐ **Resolve mdx UTI Panel**
PCR detection, ABR genes, ASTX susceptibility testing
Test details on back

☐ **Resolve mdx STI Panel**
(ADDITIONAL SPECIMEN TUBE REQUIRED)
PCR Identification, ABR genes
Test details on back

2. Specimen Information

Collection Date: Month Day Year

Collection Type: ☐ Clean catch urine ☐ Catheter urine

Is patient currently on antibiotic? ☐ Yes ☐ No

3. Required Billing Information (At least 1 ICD-10 is required per panel ordered)

UTI codes:
(Physician must include ICD-10 diagnosis to document medical necessity for UTI test.)

- ☐ N30.00 - Acute cystitis **w/o** hematuria
- ☐ N30.01 - Acute cystitis **with** hematuria
- ☐ N30.20 - Other chronic cystitis **w/o** hematuria
- ☐ N30.80 - Other cystitis **w/o** hematuria
- ☐ N30.81 - Other cystitis **with** hematuria
- ☐ N40.1 - BPH **with** Lower Urinary Tract Symptoms
- ☐ R10.30 - Lower abdominal pain, unspecified
- ☐ R30.0 - Dysuria
- ☐ R30.9 - Painful micturition, unspecified
- ☐ R31.0 - Gross hematuria
- ☐ R82.71 - Bacteriuria
- ☐ R82.81 - Pyuria
- ☐ Other:

STI codes:
(Physician must include ICD-10 diagnosis to document medical necessity for STI test.)

- ☐ A54.9 - Gonococcal infection, unspecified
- ☐ A64 - Unspecified sexually transmitted disease
- ☐ A74. 9 - Chlamydial infection, unspecified.
- ☐ Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission
- ☐ Other:

Copy of Insurance card (front and back) required.

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

Name of insurance: Member ID:

(Medicare only) Was procedure performed in hospital? If yes: ☐ hospital outpatient ☐ hospital inpatient - discharge date: Month Day Year

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

4. 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. 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.

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 to release the test results and relevant medical information to the patient's insurance carrier as part of the coverage and reimbursement process.

Place Patient Label Here

Place Provided Barcode Here

mdxhealth

Mdxhealth • 15279 Alton Parkway, Suite 100, Irvine, CA 92618 • P: 866.259.5644 • F: 949.788.0014 • E: cs@mdxhealth.com • www.mdxhealth.com

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Test Details

Urinary Tract Infection Panel

PATHOGENS TESTED

- Acinetobacter baumannii
- Citrobacter freundii
- Citrobacter koseri
- Enterobacter cloacae
- Enterococcus faecalis
- Enterococcus faecium
- Escherichia coli
- Klebsiella aerogenes
- Klebsiella oxytoca
- Klebsiella pneumoniae
- Morganella morganii
- Proteus mirabilis
- Pseudomonas aeruginosa
- Serratia marcescens
- Staphylococcus aureus
- Staphylococcus epidermidis
- Staphylococcus saprophyticus
- Streptococcus pyogenes
- Candida albicans

ABR PANEL

- Carbapenem
- Extended Spectrum Beta-Lactamase
- Fluoroquinolone
- Methicillin
- Trimethoprim/Sulfamethoxazole
- Vancomycin

Sexually Transmitted Infection Panel

PATHOGENS TESTED

- Mycoplasma genitalium
- Mycoplasma hominis
- Ureaplasma parvum
- Ureaplasma urealyticum
- Chlamydia trachomatis
- Gardnerella vaginalis
- Neisseria gonorrhoeae
- Trichomonas vaginalis

ABR PANEL

- Carbapenem
- Extended Spectrum Beta-Lactamase
- Fluoroquinolone
- Methicillin
- Trimethoprim/Sulfamethoxazole
- Vancomycin

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