At Home Cytology Requisition

Sanjiv V. Prabhu, M.D. · Medical Director

Shaded fields are required.

PATIENT INFORMATION

Last Name	First Name	MI
Street Address		Apt. #
City	State	ZIP
Date of Birth	Age	Sex
Phone #	Cell Phone #	
SSN #	Medical Record #	
Collection Date	Collection Time ☐ AM ☐ PM	

Please send copies of final report(s) to:

Physician Name	Fax #

DIAGNOSTIC INFORMATION

☐ R31.9 Hematuria, Unspecified *(599.70)*
☐ R31.0 Gross Hematuria *(599.71)*
☐ R31.1 Microscopic Hematuria *(599.72)*
☐ C67.9 Malignant Neoplasm of Bladder *(188.9)*
☐ High Grade ☐ Low Grade
☐ D09.0 Carcinoma In Situ of Bladder *(233.7)*
☐ E66.9 Obesity, Unspecified *(278.00)*
☐ R35.0 Frequency of Micturition *(788.41)*
☐ G93.3 Postviral Fatigue Syndrome *(780.79)*
☐ Other: _____

BILLING INFORMATION

Bill To:	☐ Insurance	☐ Medicare	☐ Medicaid	☐ Client	☐ Patient/Self-Pay
Service Type:	☐ Global	☐ TC ONLY	☐ TC with Global Bill	☐ PC ONLY	☐ PC with Global Bill

Primary Insurance: (or attach card copy)	Policy #	Group #
Plan name		Phone #
Plan address		
Name of subscriber	Patient relationship to subscriber	
Secondary Insurance: (or attach card copy)	Policy #	Group #
Plan name		Phone #

TEST REQUEST

☐ Cytology and FISH Molecular Assay
☐ Cytology Reflex FISH if Cytology is Atypical/Suspicious
☐ Cytology Reflex FISH if Cytology is: _____
☐ FISH Molecular Assay
☐ Cytology Only
☐ Other:_____

I authorize testing and confirm: 1) that this test is medically necessary and the results will be used in the medical management and treatment decisions for the patient; 2) that informed consent has been obtained; and 3) that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to Metamark Genetics, Inc. (Metamark). I authorize Metamark to contact the patient, if necessary, for testing authorization and discussion of financial responsibility. I authorize Metamark to release the information on this form and other information provided by me that is necessary to process a claim for this service.