

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 <input type="checkbox"/> AM <input type="checkbox"/> PM	
Please send copies of final report(s) to:		
Physician Name	Fax #	
DIAGNOSTIC INFORMATION		
<input type="checkbox"/> R31.9 Hematuria, Unspecified (599.70) <input type="checkbox"/> E66.9 Obesity, Unspecified (278.00)		
<input type="checkbox"/> R31.0 Gross Hematuria (599.71) <input type="checkbox"/> R35.0 Frequency of Micturition (788.41)		
<input type="checkbox"/> R31.1 Microscopic Hematuria (599.72) <input type="checkbox"/> G93.3 Postviral Fatigue Syndrome (780.79)		
<input type="checkbox"/> C67.9 Malignant Neoplasm of Bladder (188.9) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> High Grade <input type="checkbox"/> Low Grade		
<input type="checkbox"/> D09.0 Carcinoma In Situ of Bladder (233.7)		
BILLING INFORMATION		
Bill To: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Client <input type="checkbox"/> Patient/Self-Pay		
Service Type: <input type="checkbox"/> Global <input type="checkbox"/> TC ONLY <input type="checkbox"/> TC with Global Bill <input type="checkbox"/> PC ONLY <input type="checkbox"/> 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		
<input type="checkbox"/> Cytology and FISH Molecular Assay		
<input type="checkbox"/> Cytology Reflex FISH if Cytology is Atypical/Suspicious		
<input type="checkbox"/> Cytology Reflex FISH if Cytology is: _____		
<input type="checkbox"/> FISH Molecular Assay		
<input type="checkbox"/> Cytology Only		
<input type="checkbox"/> 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.