

ProMark® Prognostic Assay: REQUEST FORM

Please perform the following test for the patient listed below:

ProMark

Date:

Physician name:

Physician fax:

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.

Physician signature (REQUIRED):

FACILITY NAME AND ADDRESS: *(Please complete if this field is empty)*

Please send copies of final report to: *(optional)*

Name:

Fax #:

PATIENT INFORMATION *(Please complete ALL fields)*

Patient name:

Accession #/Case #:

Patient date-of-birth:

Patient phone:

Patient address:

City:

State:

Please include the following from each site of interest:

- ✓ Block or blocks with the highest Gleason Score overall (3+3 or 3+4)
 - Please submit 2 qualifying blocks when possible
 - Please do not include blocks with 100% tumor involvement
- ✓ Prostate biopsy pathology report
- ✓ Patient demographic information

CLINICAL INFORMATION

Diagnosis Code: C61: Prostate Cancer (185) Other:

Biopsy Gleason: 3+3 3+4

Clinical Stage: T1a T1b T1c T2a T2b T2c

Total # cores:

Total # cores positive:

Pre-Biopsy PSA:

INSURANCE INFORMATION

Bill to: Insurance Medicare Medicaid Patient/Self-Pay

PRIMARY INSURANCE

Plan name:

Policy #:

Group #:

Name of subscriber:

Patient relationship to subscriber:

SECONDARY INSURANCE

Plan name:

Policy #:

Group #:

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