



## PTEN/ERG Prognostic Assay: REQUEST FORM

\*ALL FIELDS ARE REQUIRED

Please perform the following test for the patient listed below:

PTEN and ERG       PTEN only

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

Patient name:

Accession #/Case #:

Patient date-of-birth:

Patient phone:

Patient address:

City:

State:

Please include the following from each site of interest: (sites diagnosed as malignant, atypical [ASAP]/suspicious, or HGPIN):

- ✓ H&E slide(s) – AREAS TO BE STUDIED MARKED BY PATHOLOGIST
- ✓ Two corresponding unstained slides OR corresponding block(s)
- ✓ Prostate biopsy pathology report
- ✓ Patient demographic information

As an alternative, please feel free to send all stained slides and blocks from the case of interest, along with the prostate biopsy pathology report. PTEN/ERG or PTEN prognostic testing will be performed on the appropriate site(s).

### CLINICAL INFORMATION

Biopsy Diagnosis Code:  R97.2 (790.93)     C61 (185)     N40.2 (600.10)     Other \_\_\_\_\_

### INSURANCE INFORMATION

Bill to:       Insurance     Medicare     Medicaid     Client     Patient/Self-Pay

Service type:     Global     TC     PC     TC with Global Bill     PC with Global Bill

#### PRIMARY INSURANCE

Policy #:

Plan name:

Group #:

Name of subscriber:

Patient relationship to subscriber:

#### SECONDARY INSURANCE

Policy #:

Plan name:

Group #:

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