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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