

**Please complete all fields to expedite processing and FAX to 888-564-9654**

**I. Account Information**

Practice Name \_\_\_\_\_ Account # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Requesting Physician (Circle One)

(a)	(b)	(c)
(d)	(e)	(f)
(g)	(h)	(i)
(j)	(k)	(l)
(m)	(n)	(o)

Physician Signature: \_\_\_\_\_

**II. Patient Demographics**

Name of Patient (LAST, FIRST, MI) – Please print \_\_\_\_\_

Street Address (including Apt. #) \_\_\_\_\_

City: \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Patient Telephone # \_\_\_\_\_ Patient's D.O.B. (MM/DD/YYYY) \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_

Medical Record Number (MRN): \_\_\_\_\_

**III. Test Menu Selections**

**Prognostic Services**

- PX105 **Prostate P<sub>x</sub>⊕**: Pathology Consultation for **Prostate Biopsy** Disease Progression / Favorable Pathology, including IF (CPT codes: 88323, 88347 x8, and 88399)
  - PX101 Prostate P<sub>x</sub>: Pathology Consultation for **Post-Prostatectomy** PSA Recurrence and Clinical Failure, including IF (CPT codes: 88323, 88347 x5, and 88399)
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- Additional Biomarkers by (IF) Immunofluorescence (88347):
- IF101 – AMACR     IF102 – AR     IF103 – CD-34
  - IF104 – CK-18     IF105 – HMWCK     IF106 – p-AKT
  - IF107 – Ki-67     IF108 – p63
  - PX104 Pathology Consultation (88323)

**IMPORTANT REMINDER:**

Please contact your Pathology Provider to have the Patient's Pathology Report and Specimens shipped to Aureon Laboratories, Inc. for Pathology Consultation.

**Diagnostic Services**

- DX101 Prostate Histology / Pathology (88305), **if positive diagnosis**, perform PX105 – Prostate P<sub>x</sub>⊕ (see description above)
- DX102 Prostate Histology / Pathology (88305)
- DX103 Prostate Histology – Technical Component Only (88305TC)

**NOTE:** Additional testing may be performed if determined to be medically necessary to render a diagnosis in the opinion of the reviewing Pathologist.

**IV. Patient Clinical History**

This information **MUST** be entered completely by Physician for ordered Tests.

Collection Date: \_\_\_\_\_

**Prostate P<sub>x</sub>⊕ Required Data for PX105**

PSA (@ time of biopsy): \_\_\_\_\_ ng / ml      Age (@ time of biopsy): \_\_\_\_\_

Palpable on DRE:     YES     NO      cTNM: \_\_\_\_\_

Biopsy Gleason Grade Dominant: \_\_\_\_\_      Secondary: \_\_\_\_\_

Total # of Biopsy Cores: \_\_\_\_\_      # of Cores Positive: \_\_\_\_\_

Percent Tumor Involvement: \_\_\_\_\_

Accession #: \_\_\_\_\_      Path Lab: \_\_\_\_\_

**Prostate P<sub>x</sub> Required Data for PX101**

PSA (pre-surgery): \_\_\_\_\_ ng / ml      pTNM: \_\_\_\_\_

Biopsy Gleason Score (Sum): \_\_\_\_\_

Prostatectomy Gleason Score (Sum): \_\_\_\_\_

Dominant Prostatectomy Gleason Grade: \_\_\_\_\_

Surgical Margins:     POSITIVE     NEGATIVE

Extracapsular Extension:     YES     NO

Lymph Node Involvement:     YES     NO

Seminal Vesicle Invasion:     YES     NO

**Prostate Biopsy Diagnosis Required Data for DX101, DX102**

PSA: \_\_\_\_\_ ng / ml      Percent Free PSA: \_\_\_\_\_

Digital Rectal Exam:     Suspicious     Non-suspicious

Previous Biopsy:     None     Negative     Suspicious     Positive

Other History: \_\_\_\_\_

**V. Patient Billing Information**

An ICD-9 Code for this patient's visit is required in order to process this requisition. Please provide the **current ICD-9 code(s)** (highest specificity) in the space provided below.

ICD-9 Code(s):     185     187.8     Other: \_\_\_\_\_

**Method of Payment**

- Bill Private Insurance (see below)
- Patient Self-Pay (see below)
- Bill Medicare    CARE #: \_\_\_\_\_
- Bill Medicaid    CAID #: \_\_\_\_\_
- Copy of Patient's Insurance Card (Front and Back) Attached (or fill out the patient's insurance information below)

Primary Insurance Name (Please print) \_\_\_\_\_

Primary Insurance Claim Submission Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Primary Insurance Phone # \_\_\_\_\_

Member ID #: \_\_\_\_\_      Group #: \_\_\_\_\_

Patient's Relationship to Insured:

Self     Spouse     Dependent     Other: \_\_\_\_\_

Name of Insured (LAST, FIRST, MI) - Please Print \_\_\_\_\_

Insured's Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Secondary Insurance:     Yes     No

**NOTE:** If you would like us to bill secondary insurance, you must attach a copy of the front and back of the secondary insurance card.

- Bill Patient at the Address Shown in Section II
- Patient Self-Pay: Check (U.S. only), certified funds, money order, or credit card information required for processing - No further billing information required.
- VISA     MASTERCARD     AMEX     Other: \_\_\_\_\_

Name as it Appears on Credit Card (Please Print) \_\_\_\_\_ Signature of Cardholder \_\_\_\_\_

Credit Card # \_\_\_\_\_ Security Code \_\_\_\_\_ Exp Date (MM/YY) \_\_\_\_\_