

Patient Information

Patient's First Name*	MI	Patient's Last Name*	Date of Birth (MM-DD-YYYY)*	Sex (Designated at Birth)
Patient's Street Address*		Suite/Apt #	City/ Town*	State/ Province*
Postal Code*	Country*	Patient's Phone Number*	Patient's Email *	

Ordering Provider's Information

Provider's First Name*	MI	Provider's Last Name*	Practice Name*		
Provider's Street Address*		Suite/Apt #	City/ Town*	State/ Province*	Postal Code*
Account #	Key Contact Name	Provider's Phone Number*	Provider's Fax Number*	Preferred Email*	

Patient Clinical Information
ICD10 Code(s)*

☐ D29.1 Benign Neoplasm of Prostate	☐ N40.2 Nodular prostate without LUTS
☐ R97.2 Elevated PSA	☐ N40.3 Nodular prostate with LUTS
☐ Other: _____	

 Patient Family History of Prostate Cancer* ☐ Yes ☐ No

Prostate-Specific Antigen (PSA)*

Most Recent PSA (Date)	PSA Value
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Patient Insurance/ Billing Information

 Please fill in the required information below and/or attach a copy of patient's insurance card(s).
 If the patient is interested in submitting a secondary insurance card, please include attachments.

☐ Insurance ☐ Medicare ☐ Patient (Self-Pay) ☐ Other

Name of Insured Person*	Name of Insurance Company*
Patient Relationship to Insured* ☐ Self ☐ Spouse ☐ Other	Policy Number*
Group Name/Number	

Return completed Test Requisition to:

Secure Fax Number: +1 (844) 333-0681

 Secure Email: testorder@mirnascientific.com

Mail: 685 US-1 South STE 110, North Brunswick, NJ 08902

*Required Information

Provider Attestation

By signing below, I, the undersigned (or my duly authorized representative), represent that I am a licensed health professional authorized to order this test. The patient has been informed of the risks, benefits and limitations of this test, as well as the implications of the results, and has been given an opportunity to ask questions and discuss concerns about this test. I confirm that the patient is 45 years old or greater, testing meets the stated indication of suspicion or risk for prostate cancer and that testing is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder for the patient.

I further attest that I have obtained from the patient all consents and authorizations required by and in compliance with applicable state and federal laws for the performance and billing of the testing being ordered.

I attest that the patient has been informed of the following:

1. If the test is billed to the patient's health insurer or plan, MiRNA Scientific, Inc. may share the information on this form and the test results with the patient's plan on the patient's behalf and the benefits will be made payable to MiRNA Scientific, Inc.
2. Patient may be responsible for amounts not paid by the plan directly to MiRNA Scientific, Inc. for the test ordered including cost-sharing obligations. Patient has been provided with, or informed how to obtain, a good faith estimate.
3. This test may not be covered by the patient's plan. If it is outside of the plan's coverage guidelines or deemed not medically necessary (e.g. - where prior authorization is required but not obtained) the patient may be responsible for the cost of the test.

Provider NPI*
Provider Signature*
Date (MM-DD-YYYY)*
For Lab Use Only

 MiRNA North Brunswick Lab
 Place accession barcode here

For Lab Use Only

 Sample Received Date:
 (MM-DD-YYYY)*