

Requisition Form

MiRNA Scientific
Transforming Cancer Management®

685 US-1 South STE 110
North Brunswick, NJ 08902
mirsentinel.com



+1(940) 647-7368 (940) MIR-SENTINEL
Secure Fax No: +1 (844) 333-0681
Secure Email: testorder@mirnascientific.com

Enter Kit ID#:

MNA _____

Place Urine Cup sticker with patient name
and DOB on Urine Collection Cup

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 #	City / Town*	State / Province*	Postal Code*	Country*
Account #	Key Contact Name	Provider's Phone Number*	Provider's Fax #*	Preferred Email		

Patient Sample Information

Sample Type: At least 30mL of voided urine collected at least 1 full hour after last urination. Sample should not be collected in the 72 hours after performing a DRE.

Collection Method: (Please Select One)*

In Office/Take Home At-Home Collection

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: _____

Has Patient had a previous miR Sentinel™ Prostate Cancer Test? Yes No

Patient Insurance/ Billing Information

Please fill in required information below or attach a copy of patient's insurance card(s).

Bill to*

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

Test Order Submission: Return completed Test Requisition to:

Secure Fax No: +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)*