Freedom PATHOLOGY PARTNERS
524 EAST ELM STREET, CONSHOHOCKEN, PA 19428 **(800-959-2846)**

Lab Use Only

MOLECULAR TEST REQUISITION

CLIENT INFORMATION *(Please check requesting physician)*

TEMPLATE, PRACTICE NAME
PRACTICE ADDRESS

___ Physician's Name, M.D. ___ Physician's Name, M.D.
___ Physician's Name, M.D. ___ Physician's Name, M.D.
___ Physician's Name, M.D. ___ Physician's Name, M.D.
___ Physician's Name, M.D. ___ Physician's Name, M.D.

PATIENT INFORMATION *(Green highlighted sections are required information)*

Please attach patient face sheet and front and back of primary and secondary insurance card:

PATIENT NAME REQUIRED
☐ ***See Attached***

Name (Last, First):_____
Date of Birth: ___/___/___ Sex: M F SS#_____
Address: _____
City: _____ State:____ Zip:_____
Home Phone #: _____ Work Phone #: _____
Medical Record #: _____

BILLING INFORMATION

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client
Insurance: _____ Policy #:_____ Group #: _____
Ins. Address: _____ City: _____ State: ____ Zip: _____
Policy Holder: _____ DOB: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client
Insurance: _____ Policy #:_____ Group #: _____
Ins. Address: _____ City: _____ State: ____ Zip: _____

I hereby authorize the release to EmeritusDX/Freedom of any medical and insurance information necessary to process claims for services provided by EmeritusDX/Freedom. I hereby authorize EmeritusDX/Freedom to pursue all necessary appeals of full or partial denials of payment in relation to services provided by EmeritusDX/Freedom

Patient Signature

CLINICAL INFORMATION

Collection Date: _____ **Clinical History:** _____

PHYSICIAN NOTICE Physician is required to (1) submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity, or (2) explain and have the patient sign an ABN.

Listed, are commonly used ICD-10 codes, however, please list all ICD-10 codes in the spaces provided to support the test request(s) or check codes that apply. Failure to provide ICD-10 code(s) could delay processing of the specimen.

BLADDER/URINE/PROSTATITIS

☐ G89.29 Other chronic pain
☐ N20.0 Calculus of kidney
☐ N30.00 Acute cystitis without hematuria
☐ N30.20 Other chronic cystitis without hematuria
☐ N39.0 Urinary tract infection
☐ N41.0 Acute prostatitis
☐ N41.1 Chronic prostatitis
☐ R31.0 Gross hematuria
☐ R31.29 Other microscopic hematuria
☐ R31.9 Hematuria, unsp
☐ R82.99 Other abnormal findings in urine
☐ Z11.8 Screen for other infection/parasitic diseases
☐ Z87.440 Personal history of urinary (tract) infections
☐ R97.20 Elevated prostate specific antigen
☐ Other: _____

MOLECULAR UTI TESTS

COLLECTION METHOD ☐ Voided Urine ☐ Catheterized Urine ☐ Post Massage Urine ☐ Rectal Swab ☐ Other:_____

☐ **UTIDX™ (ID with Susceptibility Testing)**
☐ **UTIDX™ F-AST (ID Only, NO Susceptibility Testing)**
☐ **Pre-Prostate Biopsy Rectal Swab (PPBRS)**
☐ **UTIDX™ (ID with Susceptibility Testing) + STI PANEL**

☐ **PROSTATITIS**
☐ **STI PANEL** *(Additional tube required)*
☐ **ADDITIONAL TESTS:**
(Additional tube required)

I understand that the Molecular UTI Test and Molecular Prostatitis Test involve testing comprised of multiple procedure codes (CPT codes shown below). I understand the Office of Inspector General has cautioned that using a mult-procedure test may result in ordering of tests which are not covered, reasonable or necessary, and that an individual who knowingly causes a false claim to be submitted may be subject to legal sanctions.

ORGANISMS

UTIDX™ ID TESTING FOR PATHOGENS LISTED BELOW

- ACINETOBACTER BAUMANNII
- ACTINOBACULUM SCHAALII
- AEROCOCCUS URINAE
- ALLOSCARDOVIA OMNICOLENS
- CANDIDA ALBICANS
- CANDIDA AURIS
- CANDIDA GLABRATA
- CANDIDA PARAPSILOSIS
- CITROBACTER FREUNDII
- CITROBACTER KOSERI
- COAGULASE NEGATIVE STAPH
- CORYNEBACTERIUM RIEGELII
- ENTEROBACTER AEROGENES
- ENTEROBACTER CLOACAE
- ENTEROCOCCUS FAECALIS
- ENTEROCOCCUS FAECIUM
- ESCHERICHIA COLI
- KLEBSIELLA OXYTOCA
- KLEBSIELLA PNEUMONIAE
- MORGANELLA MORGANII
- MYCOPLASMA HOMINIS
- PANTOEA AGGLOMERANS
- PROTEUS MIRABILIS
- PROTEUS VULGARIS
- PROVIDENCIA STUARTII
- PSEUDOMONAS AURUGINOSA
- SERRATIA MARCESCENS
- STAPHYLOCOCCUS AUREUS
- STREPTOCOCCUS AGALACTIAE
- UREAPLASMA UREALYTICUM
- VIRIDIANS GROUP STREP

STI PANEL

- TRICHOMONAS VAGINALIS
- NEISSERIA GONORRHOEAE-1
- NEISSERIA GONORRHOEAE-2
- BK VIRUS
- CHLAMYDIA TRACHOMATIS
- JC VIRUS
- GARDNERELLA VAGINALIS
- TREPONEMA PALLIDUM (Syphilis)

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

Physician/Authorized Signature _____ *Signature required on this order or in the patient's medical record* **Date** _____ / _____ / _____

NAME: _____ NAME: _____ NAME: _____ NAME: _____

DOB:_____ DOB:_____ DOB:_____ DOB:_____

VOIDED URINE **PROSTATE MASSAGE** **SWAB** **OTHER:**

Please make a copy of this document for your records.