RECTAL REQUISITION FORM

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MOKAN

ACCOUNT INFORMATION

_____
Ordering Facility

_____
Address

_____
City, State, Zip

_____ _____
Phone Collection Date & Time

Source of Collection
☒ Rectal Swab

PATIENT & BILLING INFORMATION

Name: _____
Last First MI

Address: _____

_____
City State Zip Code

Date of Birth: _____ Sex: ☐ M ☐ F

Social Security #: _____ Phone #: _____

☐ Insurance ☐ Medicare ☐ Medicaid
☐ Client Bill ☐ Self-Pay ☐ Workers Comp
☐ Skilled Nursing Facility ☐ Uninsured

Insurance Plan: _____

Policy #: _____ Group #: _____

Relationship to Insured: _____

**Attach Copy of Front & Back of Current Insurance Card*

PROVIDER AUTHORIZATION

Ordering Provider (please print)

X _____
Provider Signature

_____
Date

MOLECULAR PATHOGEN PANEL ORDERED

Molecular Pre-Biopsy Rectal Swab (RCT) and Reflex Phenotypic Molecular Antimicrobial Susceptibility

***REQUIRED: SELECT ONE**

☐ All organisms listed below
☐ Individual organisms selected below

Organisms:

☐ *Acinetobacter buamannii*	☐ *Enterobacter aerogenes*	☐ *Enterobacter cloacae*
☐ *Enterococcus faecalis*	☐ *Escherichia coli*	☐ *Klebsiella pneumoniae*
☐ *Morganella morganii*	☐ *Proteus mirabilis*	☐ *Proteus vulgaris*
☐ *Pseudomonas aeruginosa*	☐ *Staphylococcus aureus*	

Resistance Genes:
☐CTX-M Group 1/2 ☐QnrA/QnrB/QnrS ☐SHV ☐TEM

INDICATION FOR MEDICAL NECESSITY

***REQUIRED: SELECT ALL THAT APPLY**

☐ High risk for post-prostate biopsy sepsis or infection
☐ Prior post-prostate biopsy sepsis
☐ Recent antibiotic exposure
☐ Prostate biopsy within the last 12 months
☐ Joint replacement within the past 2 years
☐ Recent catheter placement for urinary retention
☐ Urinary catheter or self catheterization dependent
☐ History of lymphoma, leukemia, prior bone marrow transplant, chronic immunosuppression, or an autoimmune disorder/disease
☐ Healthcare worker with direct patient contact
☐ Other: _____

ICD 10 CODE(S)

***REQUIRED: SELECT ALL THAT APPLY**

☐ R97.20 Elevated PSA
☐ C61 Malignant neoplasm of prostate
☐ D40.0 Neoplasm of uncertain behavior of prostate
☐ R97.21 Rising PSA following treatment for malignant neoplasm of prostate
☐ Z85.46 Personal history of malignant neoplasm of prostate
☐ Other: _____

ADDITIONAL TEST INFO: Reflex to Phenotypic Molecular Antimicrobial Susceptibility is only performed when an eligible bacterial pathogen is detected at ≥10,000 cells/mL.

Release and Consent
As a courtesy, Mokan Labs, LLC makes every reasonable effort to obtain reimbursement for ordered tests. I authorize Mokan Lab, LLC to release to Medicare, its carriers, and any insurance carrier or health plan providing benefits to me, any information that may be needed for claim purpose. By authorizing the test, I hereby assign to Mokan Labs, LLC all Medicare, Medicaid, and/or insurance benefits related to ordered tests. I understand if my insurance company pays me directly for services rendered by Mokan Labs, LLC, I am responsible for forwarding any & all such payments directly to Mokan Labs, LLC. I also understand and agree to that I am responsible for any copayment and/or deductible, as required by my plan. In addition, I understand and agree that if for any reason the ordered & performed tests are excluded from coverage by Medicare, Medicaid, or other insurance, I am financially responsible for payment to Mokan Labs.