SEMEN REQUISITION FORM

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MOKAN

ACCOUNT INFORMATION

_____
Ordering Facility

_____
Address

_____
City, State, Zip

_____ _____
Phone Collection Date & Time

Source of Collection
☐ Ejaculation ☐ Other

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 Semen/Prostatitis with Antibiotic Resistance Genes and Reflex Phenotypic Molecular Antimicrobial Susceptibility

***REQUIRED: SELECT ONE**

☐ All organisms and resistance genes listed below
☐ Individual organisms and/or genes selected below

Organisms:

☐ *Acinetobacter baumannii*	☐ *Escherichia coli*	☐ *Providencia stuartii*
☐ *Candida albicans*	☐ *Klebsiella aerogenes*	☐ *Pseudomonas aeruginosa*
☐ *Candida glabrata*	☐ *Klebsiella oxytoca*	☐ *Serratia marcescen*
☐ *Candida parapsilosis*	☐ *Klebsiella pneumoniae*	☐ *Staphylococcus aureus*
☐ *Citrobacter freundii*	☐ *Morganella morganii*	☐ *Staphylococcus saprophyticus*
☐ *Enterobacter cloacae*	☐ *Mycoplasma hominis*	☐ *Streptococcus agalactiae (Group B)*
☐ *Enterococcus faecalis*	☐ *Proteus mirabilis*	
☐ *Enterococcus faecium*	☐ *Proteus vulgaris*	☐ *Ureaplasma urealyticum*

Resistance Genes:

☐ampC ☐CTX-M Group 1/2 ☐femA ☐KPC ☐mecA ☐Oxa-48
☐QnrA/QnrB/QnrS ☐SHV ☐TEM ☐VanA1/VanA2 ☐VanB ☐VIM/IMP-7/NDM

INDICATION FOR MEDICAL NECESSITY

***REQUIRED: SELECT ALL THAT APPLY**

☐ Concern for acute bacterial prostatitis
☐ Chronic prostatitis
☐ Prostatitis symptoms despite prior empiric treatment
☐ Prior negative semen culture with ongoing prostatitis symptoms
☐ Prior negative urine culture with ongoing prostatitis symptoms
☐ Need for semen infectious testing with no available testing options at local or hospital lab
☐ Chronic pelvic pain with prior negative work up
☐ Other: _____

ICD 10 CODE(S)

***REQUIRED: SELECT ALL THAT APPLY**

☐ N41.0: Acute prostatitis
☐ N41.1: Chronic prostatitis
☐ N41.3: Prostatocystitis
☐ N41.8: Other inflammatory diseases of prostate
☐ N49.0: Inflammatory disorders of seminal vesicle
☐ R10.2 - Pelvic and perineal pain
☐ N34.1 – Nonspecific urethritis
☐ N30.80 - Other cystitis without hematuria
☐ N30.81 - Other cystitis with hematuria
☐ R30.0 - Dysuria
☐ R30.9 – Painful micturition, unspecified
☐ R39.16 – Straining to void
☐ R10.30 – Lower abdominal pain, unspecified
☐ R10.84 – Generalized abdominal pain
☐ R39.15 – Urgency of urination
☐ Z87.440 – Personal history of urinary (tract) infections
☐ 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.