UTI REQUISITION FORM

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MOKAN

ACCOUNT INFORMATION

_____
Ordering Facility

_____
Address

_____
City, State, Zip

_____ _____
Phone Collection Date & Time

Source of Collection
☐ Clean Catch ☐ Catheterized ☐ Foley Catheter
☐ Random Void ☐ Nephrostomy Tube ☐ Kidney Stone ☐ 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 UTI with Antibiotic Resistance Genes and Reflex Phenotypic Molecular Antimicrobial Susceptibility (UTI)

***REQUIRED: SELECT ONE**

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

Organisms:

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

☐ Symptomatic AND at higher risk for UTI complications
☐ Recurrent UTI
☐ Prior negative urine culture with persistent urinary symptoms concerning for UTI
☐ Complicated UTI
☐ Dipstick or urine analysis positive
☐ Persistent UTI symptoms in setting of prior "mixed flora" or "contaminated" urine culture results
☐ Concern for UTI due to atypical organism or pathogen load not detected or reported on culture
☐ Other: _____

ICD 10 CODE(S)

***REQUIRED: SELECT ALL THAT APPLY**

☐ N30.00 – Acute cystitis without hematuria
☐ N30.01 – Acute cystitis with hematuria
☐ N30.10 – Interstitial cystitis (chronic) without hematuria
☐ N30.11 – Interstitial cystitis (chronic) with hematuria
☐ N30.80 – Other cystitis without hematuria
☐ N30.81 – Other cystitis with hematuria
☐ N34.1 – Nonspecific urethritis
☐ R10.2 – Pelvic and perineal pain
☐ R30.0 – Dysuria
☐ R30.9 – Painful micturition, unspecified
☐ R35.0 – Frequency of micturition
☐ R39.16 – Straining to void
☐ R31.0 – Gross hematuria
☐ R50.9 – Fever, unspecified
☐ R10.84 – Generalized abdominal pain
☐ R10.30 – Lower abdominal pain, unspecified
☐ R82.71 – Bacteriuria
☐ R82.81 – Pyuria
☐ R82.998 – Other abnormal findings in urine
☐ R82.79 – Other abnormal findings on microbiological examination of urine
☐ 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. I attest that this test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions.