

MYRIAD GENETIC LABORATORIES, INC. 320 Wakara Way • Salt Lake City, Utah 84108 (800) 469-7423 • (801) 584-1100 Fax (801) 883-3256 • Prolaris@myriad.com



Post-Prostatectomy Test Request Form

DATIFIE INFORMATION			ADDEDUIG DIFFE	JOIAN .		
PATIENT INFORMATION PATIENT NAME (LAST, FIRST, INITIAL)	PT ID (Optional)		ORDERING PHYSICIAN NAME (LAST, FIRST, DEGREE)			<u> </u>
TOTAL MANUE (CAST, LINOT, INTIPAL)						
SSN	□ FEMALE BIRTH ☑ MALE	DATE (MM/DD/YYYY)	MYRIAD ACCOUNT NO: (If nev	v customer or account number is un	known, please complete the add	dress info or call (800)469-7423)
STREET ADDRESS	U WALL		ADDRESS			
CITY	STATE	ZIP	CITY		STATE	ZIP
DAYTIME PHONE NUMBER	ALTERNATE PHONE NUMBER	R	OFFICE CONTACT	I	PHONE	FAX
			EMAIL			
CLINICAL INFORMATION						
☐ Prostate Cancer: Age at Dx:		Prostatectomy Gleason S	Score: \square 2 \square 3	4 5 6	3+4 🗆 4+3	8 🗆 8 🗀 9 🗀 10
☐ Pre-Operative Prostate Radiation		Positive Margins:				_, _, _,
☐ Pre-Operative Androgen Deprivation		Extracapsular Extension:			REC	QUIRED DATA FOR
☐ Date of Surgery:		Seminal Vesicle Invasion			PROLAF	RIS COMBINED SCORE
Pre-Surgical PSA:		Positive Lymph Node(s):		☐ Not Assessed		
		rositive Lymph Node(s).		□ Not Assessed		
For Medicare Patients Only:						
At the time of prostatectomy surgery:	☐ Hospital Inpatient (>24 hour	stay) Discharge Date:		☐ Hospital Outpatier	nt 🗆 Non-Hospit	tal Patient
TECT OFFEDING						
TEST OFFERING						
Prolaris Post-Prostatectomy Test						
SPECIMEN RETRIEVAL						
☐ I want Myriad Genetic Laboratories, In	c. to request the specimen. (CO	MPLETE the information b	oelow.)			
		BUONE		500	20171	
LOCATION OF SPECIMEN		PHONE		FAX	CUNTAL	CT NAME
AUTHORIZED SIGNATURE						
I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I confirm that this test is medically necessary and the results will be used in the medical management and treatment decisions for the patient. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test(s)						
requested herein. I confirm that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare services providers, such as Myriad Genetic						
Laboratories, Inc. (MGL). I authorize MGL to release the information on this form, and other information provided by me, necessary to process a claim for this service.						
			HEALTHCARE PL	ROVIDER'S SIGNATURE		DATE
			TIE/LETTO/WETT	TO VIDELLE O GIGINATIONE		D/III
BILLING/PAYMENT INFORMATION						
☐ OPTION 1: PLEASE BILL INSURANCE				r discharge date)		
(Option 1 requires enlarged copy of both		· · · · · · · · · · · · · · · · · · ·				
Name of Policy Holder:		DOB:	Insurance	ID#/SSN:		· [
Patient Relation to Policy Holder:						REMINDER: INCLUDE A COPY OF BOTH SIDES OF
MGL will contact the patient prior to test	start only if their total financial r	esponsibility will exceed 9	375 (for any reason.	. including co-insurance	e and deductible.	INSURANCE CARD(S)
or non-covered services).			, (,	,g	,	
☐ OPTION 2: PATIENT PAYMENT (Please of	call Customer Service for questions i	regarding test prices)				
☐ Please bill my credit card (all majo	or credit cards accented) in the a	mount of \$ _	Card#			Exp. Date:
Cardholder Name (please print):						F . =
			=			
☐ Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.						
OPTION 3: OTHER BILLING (To establish an account, submit billing information with this form)						
☐ Bill our institutional account #:	<i>or</i> ∈	established research proje	ct code #:	or	Authorization/Voucher	r#:
		-				