MYRIAD®

MYRIAD GENETIC LABORATORIES, INC.
320 Wakara Way • Salt Lake City, Utah 84108
Toll Free (855)-469-7765 • Fax (801) 883-3256
ProlarisCS@myriad.com

Prolaris®

Post-Prostatectomy Test Request Form

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

PATIENT ID # (OPTIONAL) ☐ FEMALE ☑ MALE BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS

CITY STATE ZIP

DAYTIME PHONE NUMBER ALTERNATE PHONE NUMBER

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE) NPI #

MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800)469-7423)

ADDRESS

CITY STATE ZIP

OFFICE CONTACT PHONE FAX

EMAIL

CLINICAL INFORMATION

☐ Prostate Cancer: Age at Dx: _____
☐ Pre-Operative Prostate Radiation
☐ Pre-Operative Androgen Deprivation
☐ Date of Surgery: _____
Pre-Surgical PSA: _____

Prostatectomy Gleason Score: ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 3+4 ☐ 4+3 ☐ 8 ☐ 9 ☐ 10
Positive Margins: ☐ Yes ☐ No
Extracapsular Extension: ☐ Yes ☐ No
Seminal Vesicle Invasion: ☐ Yes ☐ No
Positive Lymph Node(s): ☐ Yes ☐ No ☐ Not Assessed

REQUIRED DATA FOR PROLARIS COMBINED SCORE

For Medicare Patients Only:

At the time of prostatectomy surgery: ☐ Hospital Inpatient (>24 hour stay) Discharge Date: _____ ☐ Hospital Outpatient ☐ Non-Hospital Patient

TEST OFFERING

Prolaris Post-Prostatectomy Test

SPECIMEN RETRIEVAL

☐ I want Myriad Genetic Laboratories, Inc. to request the specimen. (COMPLETE the information below.)

LOCATION OF SPECIMEN PHONE FAX CONTACT 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 PROVIDER'S SIGNATURE DATE

BILLING/PAYMENT INFORMATION

☐ **OPTION 1: PLEASE BILL INSURANCE** (For Medicare patients: only available if test order date is more than 2 weeks after discharge date)
(Option 1 requires enlarged copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary)

Name of Policy Holder: _____ DOB: _____ Insurance ID#: _____

Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

MGL will contact the patient prior to test start only if their total financial responsibility will exceed $375 (for any reason, including co-insurance and deductible, or non-covered services).

REMINDER: INCLUDE A COPY OF BOTH SIDES OF INSURANCE CARD(S)

☐ **OPTION 2: PATIENT PAYMENT** *(Please call Customer Service for questions regarding test prices)*

☐ Please bill my credit card (all major credit cards accepted) in the amount of $ _____ Card# _____ Exp. Date: _____

Cardholder Name (please print): _____ Cardholder Signature: _____

☐ 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 #: _____ *or* established research project code #: _____ *or* Authorization/Voucher #: _____