Resolve mdx
for Urinary Tract Infection

Test Requisition Form

Ordering Physician

Account Information

Patient Information

Name: First Last

Address:

City: State: Zip:

Email Address: Phone:

Date of Birth: Month Day Year Sex: M F MRN/Patient ID:

1. Resolve mdx Test Requested

Checking this box is required for testing:

- **Resolve mdx Organism Identification and Susceptibility**

Urinary Tract Infection Panel

- Acinetobacter baumannii
- Candida albicans
- Citrobacter freundii
- Citrobacter koseri
- Enterobacter cloacae
- Enterococcus faecalis
- Enterococcus faecium
- Escherichia coli
- Klebsiella aerogenes
- Klebsiella oxytoca
- Klebsiella pneumoniae
- Morganella morganii
- Proteus mirabilis
- Pseudomonas aeruginosa
- Serratia marcescens
- Staphylococcus aureus
- Staphylococcus epidermidis
- Staphylococcus saprophyticus
- Streptococcus pyogenes

Antimicrobial Resistance Gene Panel

- Carbapenem
- Extended Spectrum Beta-Lactamase
- Fluoroquinolone
- Methicillin
- Trimethoprim/Sulfamethoxazole
- Vancomycin

2. Specimen Information

Collection Date: Month Day Year

Collection Type: Clean catch urine

Is patient currently on antibiotic? Yes No

3. Billing Information (ICD-10 and copy of insurance card required)

- N30.80 - Other cystitis **without** hematuria
- N30.81 - Other cystitis **with** hematuria
- R30.0 - Dysuria
- R30.9 - Painful micturition, unspecified
- R50.9 - Fever, unspecified
- R10.30 - Lower abdominal pain, unspecified
- B37.42 - Candidal balanitis
- B37.49 - Other urogenital candidiasis
- B37.41 - Candidal cystitis and urethritis
- R10.84 - Generalized abdominal pain
- N34.1 - Nonspecific urethritis
- N34.3 - Urethral syndrome, unspecified
- R82.90 - Unspecified abnormal findings in urine
- R39.16 - Straining to Void
- Other:

Payment Type: Private Insurance Medicare Medicaid Patient Self-Pay Client (contract required)

Include copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

4. Physician Signature & Attestation

I hereby authorize testing and confirm that an informed consent has been obtained, if required by state law. I confirm that this is medically necessary and the results will be used in the medical management 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 requested herein. I confirm that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers, such as mdxhealth. I further instruct mdxhealth to retain this completed test requisition as part of the patient medical record. I authorize mdxhealth to release the information on this form, and other information provided by me, or on my behalf, necessary to process a claim for this service.

Ordering Physician Signature (No stamped signatures)

Date

Submitting this form constitutes a Certification of Medical Necessity and a certification that you have obtained consent for mdxhealth to release the test results and relevant medical information to the patient's insurance carrier as part of the coverage and reimbursement process.

Place Patient Label Here

Place Provided Barcode Here

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mdxhealth