401 W. Morgan Road
Ann Arbor MI 48108
844-4Armune (844-427-6863)
www.armune.com

Apifiny® Test Requisition Form

Make a copy of completed form for your records

PHYSICIAN AND DIAGNOSIS INFORMATION

This Test CANNOT be performed without the signature of the referring physician or other approved health care provider. Signature confirms your certification of medical necessity and that you have obtained patient's permission for Armune BioScience to release test results to the patient's third-party payer as necessary when submitting for reimbursement.

Physician/Approved Provider Signature _____ Date _____

Physician/Approved Provider Name (Print) _____ NPI _____

Hospital/Clinic Name _____

Address _____

City _____ State _____ ZIP _____ Country _____

Phone _____ Ext _____ Secure FAX _____

E-Mail _____ Report Final Results by: ❑ Mail ❑ Secure FAX ❑ E-Mail

Please state why test is needed (Diagnosis/Signs/Symptoms) _____

ICD-10:
- ❑ **D29.1** Benign neoplasm of prostate
- ❑ **D49.5** Neoplasm of unspecified behavior of other genetourinary organs
- ❑ **N40.0** Enlarged prostate without lower urinary tract symptoms
- ❑ **N40.1** Enlarged prostate with lower urinary tract symptoms
- ❑ **Z12.5** Encounter for screening for malignant neoplasm of the prostate
- ❑ **N41.9** Inflammatory disease of prostate, unspecified
- ❑ **N42.9** Disorder of prostate, unspecified
- ❑ **R97.2** Elevated prostate specific antigen (PSA)
- ❑ **N41.1** Chronic prostatitis
- ❑ **Other** Please specify: _____

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Patient ID # _____ Race _____

Address _____

City _____ State _____ ZIP _____ Country _____ Phone _____

MEDICAL HISTORY

Date(s)/Result(s) of Last PSA Test(s) _____ _____ _____

Date of Last DRE _____ Result of Last DRE ❑ Normal ❑ Abnormal

Has Patient had a Prostate Biopsy? ❑ No ❑ Yes If Yes, Pathology Result _____

SAMPLE INFORMATION

Sample Type: SST ___ Red Top ___ Microtainer SST ___

Date and Time of Blood Draw _____ Sample Ship Date _____

Number of Tubes/Vials _____ Time Sample at 15-30°C _____ Draw Lab Name _____

PAYMENT INFORMATION

❑ **Patient Self-Pay** (Check or Credit Card. Check or card will be processed when results are reported to physician.)

Name on Card _____ Card No _____ Exp Date _____

Security Code _____ Billing Address _____

❑ **Primary Private Insurance Carrier** _____ **Attach front/back copy of insurance card**

Subscriber Name & Date of Birth _____ Subscriber's relation to patient _____

❑ **Secondary Private Insurance Carrier** _____ **Attach front/back copy of insurance card**

Subscriber Name & Date of Birth _____ Subscriber's relation to patient _____

❑ **MEDICARE** **Attach front/back copy of insurance card** ❑ **MEDICAID** **Attach front/back copy of insurance card**

❑ Hospital Inpatient (more than 24-hr stay)
❑ Hospital Outpatient ❑ Non-hospital patient

NOTE: If patient requests information on insurance coverage, please FAX completed Requisition Form and insurance carrier details to 734-424-1170. If there are further questions about insurance coverage, please call 866-661-8555.