Mindera HEALTH Complete and Fax this form to **858-225-4178**

Test Request Form

PATIENT INFORMATION

Name — First | Middle | Last

Address — Street | Apartment #/Unit | City | State | ZIP Code | Email | Phone Number

ID — Date of Birth | SSN or Medical Record number

Physical — Gender: ☐ Male ☐ Female | Date Sample Collected | Body Weight (lb) | Height (inches)

Ethnicity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Other

PAYMENT & INSURANCE INFORMATION

Payment Method: ☐ Insurance ☐ Medicare ☐ Self-Pay ☐ Direct Client Bill

Primary Insurance — Name | Member Name (if different from patient) | Member Date of Birth | Member ID# | Group #

Secondary Insurance — Name | Member Name (if different from patient) | Member Date of Birth | Member ID# | Group #

Attachment — Attach a copy (Front and Back) of Insurance Card(s) | Rx BIN# | Rx PCN#

GUARANTOR INFORMATION

Relationship to Patient

Name — First | Middle | Last

Address — Street | Apartment #/Unit | City | State | ZIP Code | Email | Phone Number

PRACTICE INFORMATION

Physician Name | Practice Name

Account / Client ID# | NPI #

SPECIMEN INFORMATION

Specimen Collected on (Date) | Specimen Tube Label

Sample Collection Location Required *(Please check box for specimen collection location)*

Limb:			Head & Neck:		Trunk:	
☐ Right Upper Arm	☐ Right Hand	☐ Right Calf	☐ Forehead	☐ Nose	☐ Right Shoulder	☐ Abdomen
☐ Left Upper Arm	☐ Left Hand	☐ Left Calf	☐ Right Ear	☐ Cheek	☐ Left Shoulder	☐ Back
☐ Right Forearm	☐ Right Thigh	☐ Right Foot	☐ Left Ear	☐ Neck	☐ Chest	
☐ Left Forearm	☐ Left Thigh	☐ Left Foot				

☐ Other, specify

TEST ORDER

☐ Mind.Px — Patient Type Required (Select One) ☐ Initial Biologic Therapy ☐ Switching Biologic Therapy

ICD-10 CODE

Select all that apply. Codes below are not exhaustive. Provide additional information as necessary.

Psoriasis Type

☐ Plaque Psoriasis (L40.0) ☐ Guttate Psoriasis (L40.4) ☐ Flexural or Inverse Psoriasis (L40.8) ☐ Pustular Psoriasis (L40.1)

☐ Psoriatic Arthritis (L40.52) ☐ Erythrodermic Psoriasis (L40.8) ☐ Others, specify

HEALTH PROVIDER AUTHORIZATION

I, the undersigned*, attest that I ordered the Mind.Px test for my eligible patient and this order is appropriately documented in the Patient Medical record. The test is medically necessary and reasonable to provide information to allow me to personalize treatment for my patient's medical condition.

Treating Physician Signature (or Authorized Delegate) | Date (mm/dd/yyyy)

**Delegate has the authorization to sign supporting form and documents on behalf of the Treating Physician*