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

Test Request Form

SPECIMEN INFORMATION

Collection Method ☐ Mobile ☐ Provider

Collection Date : _____ Specimen ID : _____

e.g CMA000000

Specimen Collection Location

Limb:

☐ Right Upper Arm ☐ Right Hand ☐ Right Calf
☐ Left Upper Arm ☐ Left Hand ☐ Left Calf
☐ Right Forearm ☐ Right Thigh ☐ Right Foot
☐ Left Forearm ☐ Left Thigh ☐ Left Foot

Head & Neck:

☐ Forehead ☐ Nose
☐ Right Ear ☐ Cheek
☐ Left Ear ☐ Neck

Trunk:

☐ Right Shoulder ☐ Abdomen
☐ Left Shoulder ☐ Back
☐ Chest

☐ Other, Specfiy _____

Patient Type Required (Select One) ☐ Initial Biologic Therapy ☐ Switching Biologic Therapy

PATIENT INFORMATION

Name First _____ Middle _____ Last _____

Address Street _____ Apartment #/Unit _____

City _____ State _____ ZIP Code _____

Email _____ Phone Number _____

Date of Birth _____ Body Weight (lb) _____ Height (inches) _____

Sex ☐ Male ☐ Female

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

INSURANCE INFORMATION

Attachment Attach a copy (Front and Back) of Insurance Card(s)

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

Primary Insurance

Insurance Name _____

Subscriber Name (if different from patient) _____

Relationship To Subscriber _____ Subscriber Date of Birth _____

Subscriber ID # _____ Subscriber Sex ☐ Male ☐ Female

Group # _____

TEST INFORMATION

Mind.PX™ TEST DESCRIPTOR Autoimmune (psoriasis), mRNA, next-generation sequencing, gene expression profiling of 50-100 genes, skin- surface collection using adhesive patch, algorithm reported as likelihood of response to psoriasis biologics. (CPT Code: 0258U)

ICD-10 CODE *(Select all that apply)*

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 _____

PROVIDER INFORMATION

Provider Name _____ Practice Name _____

Provider NPI # _____ Account / Client ID# _____

Report Delivery Method ☐ E-mail ☐ Fax _____

Completion of this section authorizes Mindera Health to release the final test report to the above report delivery method for treatment purposes of the patient.

HEALTH PROVIDER CERTIFICATION OF MEDICAL NECESSITY

By submitting this form, I attest that all information listed above is accurate and complete. I also acknowledge that my submission of this form reflects my agreement to provide to Mindera Health any documentation supporting the medical necessity of the Mind.Px™ Test, (the 'Test'), ordered on this form upon request as well as my agreement to cooperate fully in any query or request from any third-party payor related to the test ordered on this form. I attest that I ordered the 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 and I have obtained informed consent from the patient, who has consented to testing as may be required by law and I have provided the patient a copy of the Mindera Health Mind.Px Informed Consent form. The patient has been fully informed of the details of the Test, including the purpose, risks, benefits, and alternatives. The patient has consented to Mindera Health to release test results to the third-party payer (health insurer) when necessary, as part of the reimbursement process, with all benefits of the plan payable directly to Mindera Health. The patient assigns Mindera Health the right to appeal on their behalf negative coverage decisions made by the plan and to assert all rights and claims reserved to them as the beneficiary thereof. The patient understands that Mindera Health will contact them to coordinate the receipt and/or delivery of the Mind.Px test and billing inquiries.

_____ _____

Ordering Provider Signature (or Authorized Delegate*) Date (mm/dd/yyyy)

*Delegate has the authorization to sign supporting form and documents on behalf of the Ordering Provider