Complete, print and submit

Reset Form

MAYO CLINIC
Mayo Medical Laboratories

Prostate Health Index (phi), Serum Test Request Form

PHI11/ Prostate Health Index (phi), Serum

Submitting Provider/Provider Name Information (required)

Submitting/Referring Provider *(Last, First)*
Fill in only if Call Back is required. Phone ( ) _____ – _____ Fax* ( ) _____ – _____
Provider's National I.D. (NPI)

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Address		
City	State	Zip Code

Patient Information (required)

Patient ID *(Medical Record No.)*		
Patient Name *(Last, First, Middle)*		
Gender ☐ Male ☐ Female	Birth Date *(Month DD, YYYY)*	
Collection Date *(Month DD, YYYY)*	Time ☐ a.m. ☐ p.m	
Patient's Street Address		
Phone		
City	State	Zip Code

ICD-10 Diagnosis Code

Billing Information

Subscriber's Name *(if different than patient)*		
Patient Relationship ☐ Spouse ☐ Dependent ☐ Other _____		
Medicare HIC Number *(if applicable)*		
Medicaid Number *(if applicable)*		
Insurance Company's Name *(if applicable)*		
Insurance Company's Street Address		
City	State	Zip Code
Policy Number		
Group Number		

Ship specimens to:
Mayo Medical Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Billing Information
- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

Visit www.MayoMedicalLaboratories.com for the most up-to-date test and shipping information.

Print

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