Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Prostate Health Index (phi), Serum Test Request

PHI11/ Prostate Health Index (phi), Serum

Client Information (required)

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

Submitting Provider Information (required)

Submitting/Referring Provider Name *(Last, First)*

Fill in only if Call Back is required.

Phone (with area code)	Fax (with area code)
Provider's National I.D. (NPI)	

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

ICD-10 Diagnosis Code

Patient Information (required)

Patient ID (Medical Record No.)	
Patient Name *(Last, First, Middle)*	
Sex ☐ Male ☐ Female	Birth Date *(mm-dd-yyyy)*
Collection Date *(mm-dd-yyyy)*	Time ☐ am ☐ pm

Billing Information

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

Ship specimens to:

Mayo Clinic Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

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

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)

Print