

**PHI11/ Prostate Health Index (phi), Serum**

**Submitting Provider/Provider Name Information**  
(required)

Submitting/Referring Provider <i>(Last, First)</i>	
<b>Fill in only if Call Back is required.</b>	
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 <i>(Medical Record No.)</i>	
Patient Name <i>(Last, First, Middle)</i>	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date <i>(Month DD, YYYY)</i>
Collection Date <i>(Month DD, YYYY)</i>	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m
Patient's Street Address	
Phone	
City	State    Zip Code
ICD-10 Diagnosis Code	

**Billing Information**

Subscriber's Name <i>(if different than patient)</i>		
Patient Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		
Medicare HIC Number <i>(if applicable)</i>		
Medicaid Number <i>(if applicable)</i>		
Insurance Company's Name <i>(if applicable)</i>		
Insurance Company's 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](http://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)