SONIC REFERENCE LABORATORY

PromarkerD
Diabetic Kidney Disease Risk Assessment Test Requisition

PATIENT INFORMATION

Last Name _____ M.I. _____ Biological Sex ☐ Female ☐ Male

First Name _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Date of Birth ___/___/___ Medical Record # _____ Patient Phone # ___–___–_____

ACCOUNT INFORMATION

PAYMENT AND INSURANCE

☐ Self-Pay ☐ Medicaid ☐ Client Bill ☐ Bill Insurance

Attach copy of front and back of insurance card

Insurance Name _____

Subscriber Name _____ ID # _____

Group # _____ Pre-authorization # _____

ICD-10 Diagnosis Code _____

CLINICIAN SIGNATURE

Statement of Medical Necessity:

When ordering tests for which reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for diagnosis or treatment of a patient or monitoring disease progression.

Clinician Signature _____ Date _____

SAMPLE COLLECTION — (Complete A, B, and C)

A. Collection Date (MM/DD/YYYY): _____ **B. Collection Time:** _____ **C. Write patient's full name and date of birth on all tubes**

PATIENT SIGNATURE FOR INFORMED CONSENT AND FINANCIAL RESPONSIBILITY

I accept full financial responsibility for any payment obligation associated with my test(s). I understand that I am responsible for any applicable co-payment, coinsurance, or deductible as specified by my health plan, including any costs relating to out-of-network, non-covered, or non-authorized services. I understand that SHUSA and its affiliates will bill my health plan as required by my insurer and in accordance with its policies unless otherwise notified. If applicable, I authorize SHUSA to appeal any coverage denial made by my insurer on my behalf. I understand to direct all cost estimates and coverage inquiries to my insurer or, if I am uninsured, to SHUSA and its affiliates. I further authorize my health plan/insurance carrier to directly pay SHUSA and its affiliates for services rendered. I understand that I may be responsible for portions of this test not covered by my insurance. ***State of Nevada residents must file a separate consent form.***

Patient Signature _____ Date _____

ORDERING INFORMATION

☐ Test Set C370, PromarkerD

CLINICAL INFORMATION

Diabetes is the number one cause of kidney failure with 1 out of 3 patients with type 2 diabetes developing diabetic kidney disease (DKD). Early identification can delay or prevent progression of DKD. However, conventional assessment and monitoring (ACR, eGFR) cannot predict risk of developing DKD, which is usually detected only after kidney damage has occurred. PromarkerD generates a risk score of developing DKD within the next four years in patients with type 2 diabetes through measurement of 3 plasma biomarkers by ELISA combined with age, HDL-cholesterol, and eGFR.

INDICATIONS FOR TESTING

PromarkerD is indicated in type 2 diabetic patients regardless of current renal function status to evaluate the current glomerular damage and to predict renal function decline in the following 4 years.

SONIC HEALTHCARE USA

Sonic Healthcare USA
12357-A Riata Trace Parkway, Suite 210
Austin, TX 78727

www.sonichealthcareusa.com
P: 512.439.1600

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