FRY LABORATORIES, L.L.C. - *Requisition* (Insurance)
14807 N. 73rd Street, Suite 103 Scottsdale, AZ 85260
(866)927-8075 phone (480)656-4932 fax frylabs.com CLIA#03D1026968

_____/_____/_____
LAB BILL NP

LAB USE ONLY

v01.10.2018ins

HEALTHCARE PROVIDER INFORMATION

Physician Name: _____ NPI#: _____
Facility / Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____ Fax: (____)_____

PHYSICIAN INFORMED CONSENT ATTESTATION *Healthcare Provider Signature Required*

I, the listed ordering healthcare provider, confirm that this test is medically necessary for the diagnosis or detection of a disease, infection, illness, impairment, symptom, syndrome, or disorder. These results will be used as part of the medical management and treatment decisions for the patient. I will provide appropriate ICD-10 diagnosis codes to support testing. I confirm that I am authorized by law to order the test(s) requested herein. I am aware that DNA sequencing may detect organisms of unknown clinical significance and that results are the closest known match. I understand that test requests without this section completed will not be processed.

Healthcare Provider Signature: _____ **Date:** ____ / ____ / _____

PATIENT AND SAMPLE INFORMATION (*ICD-10 codes are required as part of the medical necessity attestation*)

Last Name: _____ First Name: _____
Mailing Address: _____ Phone: (_____)_____ Email: _____
City: _____ State: _____ Zip: _____ Gender: ❑male ❑female DOB: ____/____/_____
ICD-10 Codes: _____ _____ _____ Collection Date: _____/_____/_____ Time: _____

TEST OPTIONS (*indicate sample type below*)

SELECTION

❑	*Pan-Bacterial (Bacteria / Archaea) DNA Analysis*	$1495
❑	*Pan-Eukaryotic (Protozoa / Fungi) DNA Analysis*	$1495

SAMPLE

❑	Blood (submit lavender top)	❑	Fluid: _____(submit red top)
❑	Stool (submit swab)	❑	Tissue: _____(collection cup)

PAYMENT / BILLING OPTIONS (*please select one of three options by checking the box*)

❑ Option 1: PATIENT SELF-PAYMENT _____ *Payment Authorization for Total Amount Due*

I, the listed patient, freely elect to personally furnish payment for the cost of this test as provided to me by the Billing Office at Fry Laboratories, LLC. I understand that failure to provide pre-payment for the requested services, in full, may result in delays of the test results. I have completed the Payment Information Section.

❑ Option 2: INSURANCE *Deposit Authorization for $395 USD per test, Insurance Information, and Copy of Both Sides of Insurance Card(s)*

I, the listed patient, state that I am covered by insurance and authorize Fry Laboratories, LLC to provide my insurance carrier, health plan, or third party administrator (collectively "My Insurance") the information on this form and other information provided by my ordering healthcare provider required for reimbursement. I authorize My Insurance benefits to be payable to Fry Laboratories, LLC. I understand that I am required to provide a deposit ($395 USD **per test**) in full prior to testing that may not be refunded to me. I am aware that My Insurance may not cover the cost of this test and I may be required to pay additional fees. If my responsibility is expected to exceed $500 USD, I will be contacted prior to testing. If I cancel prior to testing, I may still be responsible for shipping and administrative costs. I have completed both the Insurance and Payment Information Sections. Any balance owed after insurance submission will be charged to the provided credit card or to the patient.

❑ Option 3: MEDICARE, MEDICAID, TRICARE, ACCESS *Medicare Information and Copy of Both Sides of Insurance Card(s)*

I, the listed patient, state that I am covered by Medicare, Medicaid, Tricare, Access, or another equivalent governmental insurance carrier and I authorize Fry Laboratories, LLC to provide my insurance carrier, health plan, or third party administrator (collectively "My Insurance") the information on this form and other information provided by my ordering healthcare provider required for reimbursement. I authorize My Insurance benefits to be payable to Fry Laboratories, LLC. By providing an Advanced Beneficiary Notice (ABN) form I understand I may be responsible for portions or the cost of the test. I have completed the Payment Information Section and I have also provided an ABN form. The ABN form can be found at: www.frylabs.com

PAYMENT INFORMATION SECTION (*required for Option 1, 2, and 3*)

Payment Type: ❑VISA ❑MasterCard ❑Discover ❑American Express ❑Check #_____
Name On Card: _____ Expiration: ____/_____ Security Code: _____ Zip: _____
Card Number: _____ **Card Holder Signature:** _____

INSURANCE INFORMATION SECTION (*required for Option 2 or 3*)

INCLUDE A LEGIBLE COPY OF BOTH SIDES OF THE INSURANCE CARD(S). INSURANCE INFORMATION MUST BE PROVIDED WITH EACH REQUISITION.

Insurance Company: _____ Insurance Phone: (____)_____
Policy Holder: _____ Holder DOB: ____/____/_____ Insurance ID#: _____
Insurance Address: _____ Patient Relation To Policy Holder: _____

PATIENTS WITH OR OF MEDICARE AGE: I AM AWARE THAT MEDICARE MAY NOT COVER THIS TEST. INCLUDE A COMPLETE ADVANCED BENEFICIARY NOTICE (ABN).

Patient / Responsible Party Signature: _____ **Date:** ____ / ____ / _____

Fry Laboratories does not accept samples drawn/obtained in the state of New York. Some tests use components that are for Research Use Only. Please visit our website for more information about each assay. Physicians with Medicare Patients: When ordering tests for which Medicare reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis / treatment of a patient, rather than for screening purposes.