FRY LABORATORIES, L.L.C. - *Requisition* (domestic)
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

v03.01.2019

HEALTHCARE PROVIDER INFORMATION (*Signature is required*)

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 INFORMATION (*Signature is required*)

Last Name: _____ First Name: _____

Mailing Address: _____ Phone: (_____)_____ Email: _____

City: _____ State: _____ Zip: _____ Gender: ◯ male ◯ female DOB: ____/____/_____

Patient or Guardian Signature: _____ **Date:** ____/____/_____

PAYMENT INFORMATION (*Select a payment method and signature is required*)

Payment Type: ◯ VISA ◯ MasterCard ◯ Discover ◯ American Express ◯ Check #_____

Card Number: _____ Name On Card: _____

Card Holder Signature: _____ Expiration: ____/_____ Security Code: _____ Zip: _____

◯ Option 1: PATIENT SELF-PAYMENT (*Provide payment information*)

I, the listed patient, choose to provide payment for the requested tests when they are received. 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: MEDICARE, MEDICAID, TRICARE, ACCESS (*Provide copy of insurance card (both sides), ABN, and payment information*)

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

TEST ORDER AND SAMPLE INFORMATION (*ICD-10 Codes and Collection Date are required*)

Dx ICD-10 Codes: _____ _____ _____ Collection Date: _____/_____/_____ Time: _____

◯ Sequencing Tests / Panels (complete sample type) — A

- ◯ Pan-Bacterial (Bacteria/Archaea) DNA Analysis
- ◯ Pan-Eukaryotic (Protozoa/Fungi) DNA Analysis
- ◯ Pan-Eukaryotic DNA Analysis + Mosaic Stain

Sample Type (select sample type)

- ◯ Blood Sample (submit lavender)
- ◯ Stool Sample (submit stool kit)
- ◯ Fluid Sample (CSF, Joint, Sputum) (submit red top)
- ◯ Tissue Sample (submit tissue kit)
- ◯ Other: _____ (contact lab)

◯ Stained Blood Film Test (submit lavender) — B

Modified May-Grünwald & Giemsa Stains

◯ Advanced Stain Test (submit lavender) — C

Fluorescent DNA Stain

◯ Mosaic Fungi Stain Test (submit lavender) — M

Fluorescent Fungi and DNA Stain

◯ Complete Stain Profile (submit lavender) — D

Modified May-Grünwald & Giemsa Stains
Fluorescent DNA Stain

◯ Mosaic Fungi Stain Profile (submit lavender) — E

Modified May-Grünwald & Giemsa Stains
Fluorescent Fungi and DNA Stain

◯ Complete Serology Profile (submit tiger) — F

Anaplasma phagocytophilum IFA IgM/IgG
Babesia microti IFA IgM/IgG
Bartonella quint./hens. IFA IgM/IgG
Ehrlichia chaffeensis IFA IgM/IgG
Lyme Line Blot IgM/IgG
Q-Fever (Coxiella burnetii) IFA IgM/IgG
Rickettsia rickettsii/typhi IFA IgM/IgG
Toxoplasma gondii IFA IgM/IgG

◯ Complete Serology Profile (submit lav & tiger) — G

Anaplasma phagocytophilum IFA IgM/IgG
Babesia microti IFA IgM/IgG
Bartonella quint./hens. IFA IgM/IgG
Ehrlichia chaffeensis IFA IgM/IgG
Lyme Line Blot IgM/IgG
Q-Fever (Coxiella burnetii) IFA IgM/IgG
Rickettsia rickettsii/typhi IFA IgM/IgG
Toxoplasma gondii IFA IgM/IgG
Modified May-Grünwald & Giemsa Stains
Fluorescent DNA Stain

LAB USE ONLY

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.