LAB REQUISITION (insurance)

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frylabs.com CLIA#03D1026968

____/____/____
LAB BILL NP

LAB USE ONLY

v06292021i

HEALTHCARE PROVIDER INFORMATION (Physician signature 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

Last Name: _____ First Name: _____ Gender: ◯ male ◯ female

Mailing Address: _____ Phone: _____ DOB: ____/____/_____

City: _____ State: _____ Zip: _____ Email: _____

Patient or Gaurdian Signature: _____ Date: _____ / _____ / _____

PAYMENT METHOD (Select Option 1, 2, or 3 below)

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

I, the listed patient, choose to provide payment for the requested tests when they are received by the laboratory. I understand that failure to provide pre-payment, in full, for the requested services may result in delays of the test results. I have completed the Payment Information section below.

◯ OPTION 2: PRIVATE INSURANCE (Payment information for deposit, insurance information, and copy of both sides of cards)

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 ($295 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 (Copies of both sides of insurance card, 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

PAYMENT INFORMATION (Required for Option 1, 2, and 3)

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

Card Number: _____ Name On Card: _____

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

INSURANCE INFORMATION (Required for Option 2 and 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: _____ / _____ / _____

TEST ORDER AND SAMPLE INFORMATION (ICD-10 codes and collection date is required)

DX ICD-10 Codes: _____ _____ _____

Collection Date: ____/____/_____ Time: _____

DNA NEXT-GENERATION SEQUENCING TESTS

◯ **BACTERIAL NEXT-GENERATION DNA SEQUENCING**
Pan-Prokaryotic (Bacteria/Archaea)

◯ **FUNGAL NEXT-GENERATION DNA SEQUENCING**
Pan-Eukaryotic (Protozoa/Fungi)

SAMPLE TYPE (Select a sample type)

- ◯ Urine (submit urine kit)
- ◯ Respiratory (submit sputum kit)
- ◯ Blood (submit lavender top tube)
- ◯ Wound (submit wound kit)
- ◯ Stool (submit stool kit)
- ◯ Fluid: CSF, Joint, etc. (submit red top tube)
- ◯ Tissue (submit tissue kit)
- ◯ Other: _____ (contact lab)

Fry Laboratories, LLC 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.