



LAB REQUISITION (non-insurance)
 14807 N. 73rd St., Ste 103
 Scottsdale, AZ 85260
 P:866.927.8075 F:480.656.4932
 frylabs.com CLIA#03D1026968

LAB BILL NP

LAB USE ONLY
 v06292021

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 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 or 2 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: 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 and 2)

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

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

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

MICROSCOPY TESTS (lavender top tube)

<input type="checkbox"/> Special Stains Test Modified May-Grünwald & Giemsa Stains	\$199
<input type="checkbox"/> Fluorescent DNA Stain Test Wet-Mount H ₂ Ochst DNA Stain	\$199
<input type="checkbox"/> Fungal Stain Test Wet-Mount Calcofluor White and DNA Stains	\$199
<input type="checkbox"/> Any two microscopy tests (mark above)	\$299
<input type="checkbox"/> All three microscopy tests	\$399

SEROLOGY TESTS (tiger top SST tube)

<input type="checkbox"/> Anaplasma phagocytophilum IFA IgM/IgG	\$199
<input type="checkbox"/> Babesia microti IFA IgM/IgG	\$199
<input type="checkbox"/> Bartonella quintana/henselae IFA IgM/IgG	\$199
<input type="checkbox"/> Ehrlichia chaffeensis IFA IgM/IgG	\$199
<input type="checkbox"/> Lyme Line Blot IgM/IgG	\$199
<input type="checkbox"/> Q-Fever (Coxiella burnetii) IFA IgM/IgG	\$199
<input type="checkbox"/> Rickettsia rickettsii/typhi IFA IgM/IgG	\$199
<input type="checkbox"/> Toxoplasma gondii IFA IgM/IgG	\$199
<input type="checkbox"/> Any two serology tests (mark above)	\$299
<input type="checkbox"/> Any three serology tests (mark above)	\$399
<input type="checkbox"/> All eight serology tests	\$999

SARS-CoV-2 (COVID-19) TESTS (lavender top tube)

<input type="checkbox"/> SARS-CoV-2 Immunoglobulin Serology	\$165
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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.