LAB REQUISITION (non-insurance)

14807 N. 73rd St., Ste 103
Scottsdale, AZ 85260
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frylabs.com CLIA#03D1026968

____/____/____
LAB BILL NP

LAB USE ONLY

v03162022ni

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: _____ Sex*: ◯male ◯female ◯other_____

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 are required)

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

MICROSCOPY TESTS (lavender top tube)

◯ **Modified May-Grünwald & Giemsa Stains** Fixed Giemsa and Jenner Stains (Special Stains)	$199
◯ **Fluorescent DNA Stain Test** Wet-Mount Höechst DNA Stain (Advanced Stain)	$199
◯ **Fungal Stain Test** Wet-Mount Calcofluor and DNA Stains (Mosaic Stain)	$199
◯ Any two microscopy tests (mark above)	$299
◯ All three microscopy tests	$399

SEROLOGY TESTS (tiger top SST tube)

◯ **Anaplasma phagocytophilum IFA IgM/IgG**	$199
◯ **Babesia microti IFA IgM/IgG**	$199
◯ **Bartonella quintana/henselae IFA IgM/IgG**	$199
◯ **Ehrlichia chaffeensis IFA IgM/IgG**	$199
◯ **Lyme Line Blot IgM/IgG**	$275
◯ **Q-Fever (Coxiella burnetii) IFA IgM/IgG**	$199
◯ **Rickettsia rickettsii/typhi IFA IgM/IgG**	$199
◯ **Toxoplasma gondii IFA IgM/IgG**	$199
◯ Any two serology tests (mark above)	$398
◯ Any three serology tests (mark above)	$575
◯ All eight serology tests	$1,499

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.
* Sex information collected for insurance reimbursement purposes. Please indicate sex as provided to insurance.