LABORATORY REQUISITION

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CLIA#03D1026968
frylabs.com

_____/_____/_____

LAB BILL NP
LAB USE ONLY

LAB USE ONLY

HEALTHCARE PROVIDER INFORMATION

Healthcare Provider Name:_____
NPI#: _____ Is Provider Signed up for Electronic Results? ☐Yes ☐No
Facility/Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax: _____ Healthcare Provider Email: _____

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 pro**cessed.**

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

PATIENT INFORMATION

Last Name:_____ First Name: _____ Gender*: ☐Male ☐Female DOB: ____/____/_____ Phone: _____
Mailing Address: _____ City: : _____ State:____ Zip:_____ Email**:** _____

Patient or Guardian Signature: _____ **Today's Date:** ____/____/_____

PLEASE SELECT A PAYMENT METHOD FROM THE OPTIONS BELOW:

☐ **OPTION 1: Patient Self-Payment** ***(Accepted for all tests)***

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** **(ONLY** ***Accepted for Next-Generation Sequencing tests)***

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 of $500 USD (Next-Gen Seq ONLY)) 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. Any balance owed after insurance submission will be charged to the provided credit card or to the patient **I have completed both the Insurance and Payment Information Sections and provided a copy of both sides of insurance card(s).**

☐ **OPTION 3: Medicare, Medicaid, Tricare, Access** ***(ONLY Accepted for Next-Generation Sequencing tests)***

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 this link: www.frylabs.com

REQUIRED: PAYMENT INFORMATION

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

INSURANCE INFORMATION

INCLUDE A LEGIBLE COPY OF BOTH SIDES OF THE INSURANCE CARD(S) INCLUDING SECONDARY INSURANCE(S)

Insurance Company: _____ Policy Holder/Subscriber Name: _____ Holder DOB: ____/____/_____
Insurance ID#: _____ Group#:_____
Insurance Address: _____Insurance Phone: _____ Patient Relation to Policy Holder: _____
Patient / Responsible Party Signature: _____ **Date:** ____/____/_____

REQUIRED: COLLECTION DATE, and ICD-10 CODES

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

TEST ORDER, SELF-PAYMENT DISCOUNTED PRICE, and SAMPLE INFORMATION

NEXT-GENERATION SEQUENCING

☐ **RIDI™: Rapid Infectious Disease Identification: $1,495**

A comprehensive next-generation DNA sequencing assay for the detection of Bacteria, Archaea, Protozoa, and Fungi. Analysis is provided by our proprietary RIDI™ software

PLEASE INDICATE SAMPLE TYPE (select from below)

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

MICROSCOPY (lavender-top tube) *insurance NOT accepted*

☐**SPECIAL STAIN:** **$295**
Fixed Giemsa, Jenner, & Modified May-Grünwald Stains for visualizing hematological elements and pathogens

☐**ADVANCED STAIN:** **$295**
Fluorescent wet-mount Höechst stain for visualizing hematological and DNA elements

☐**MOSAIC STAIN:** **$295**
Fluorescent wet-mount Calcofluor White and Ethidium Bromide stain for visualizing fungal and DNA elements

☐**ANY TWO MICROSCOPY TESTS (check two):** **$395**
☐**ALL THREE MICROSCOPY TEST** **$495**

SEROLOGY (submit serum: tiger-top SST tube) *insurance NOT accepted*

☐**Lyme Line Blot IgM/IgG** **$395**

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. Fry Labs is considered "Out-of-Network" and microscopy is not billable to any insurance. *Sex information collected for insurance reimbursement purposes. Please indicate sex as provided to insurance.