clinLGX

TEST REQUISITION FORM

1 PATIENT DEMOGRAPHIC INFORMATION

(REQUIRED – THIS **PAGE** AND **COPY OF VALID DRIVER'S LICENSE**):

Last Name/First Name/M.I.

/ /

Address/City/State/Zip

/ / /

Contact Phone Number (_____-_____-_____) **DATE OF BIRTH:** ____/____/_____

☐ MALE ☐ FEMALE RACE: _____

PAYMENT INFORMATION

(**REQUIRED** – photocopy of **both sides/INSURANCE CARD(s); both sides/VALID CREDIT CARD):**

☐ **INSURANCE** (PROVIDE CARD): ☐ **CASH (SELF PAY)** ☐ **CLIENT PAY**

☐ **WORKER'S COMP** ☐ **AUTO**

SPECIMEN INFORMATION

COLLECTION DATE:___/___/_____

TIME_____ (24-hour time) ☐ **Fasting** ☐ **Non-fasting**

☐ **Serum** ☐ **Dry Blood Spot Card (DBS)** **Number of Cards Included** _____

Phlebotomist Name:_____

2 PROVIDER INFORMATION

(INCLUDE **MEDICAL NECESSITY ICD-10 CODES/NOTES** BELOW):

Practice or Clinic Name

Address/City/State/Zip

/ / /

Ordering Provider/NPI

/ Phone Number (_____-_____-_____)

DIAGNOSIS CODES REQUIRED.

PLEASE PROVIDE ALL RELEVANT ICD-10 CODES for medical necessity per each test.

SEE commonly used ICD10 codes at bottom of form.

LIST ICD-10 CODES BELOW: **ADDITIONAL TEST REQUESTS:**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

Provider Signature _____

3 RUALLERGIC™ Custom Allergy Profiles

Please check the drop next to the profile defined in section 3 that you wish to run. Testing will only be conducted for the profiles that are checked."

Household

This test identifies common allergens such as dust mites, mold, and pet dander that can contribute to allergic reactions. By understanding your exposure to these triggers, you can create a safer and healthier living space for you and your family.

COMMONLY USED ICD-10 CODES. **These codes are provided as a convenience only; it is not a comprehensive list.**

J309 - Allergic rhinitis, unspecified
J45909 - Unspecified asthma, uncomplicated
J45901 - Unspecified asthma with (acute) exacerbation
J45902 - Unspecified asthma with status asthmaticus
J684 - Hypersensitivity pneumonitis due to organic dust
J209 - Acute bronchitis, unspecified
J82 - Asthma due to allergic reaction to dust mites
T7840XA - Allergy, unspecified, initial encounter
R060 - Dyspnea
R0902 - Hypoxemia
R05 - Cough
R0989 - Other specified symptoms and signs involving the circulatory and respiratory systems
Z77121 - Contact with and (suspected) exposure to allergens
R6883 - Fatigue, unspecified
R51 - Headache
J029 - Acute pharyngitis, unspecified (for sore throat)
J00 - Acute nasopharyngitis (common cold, for nasal congestion)
R062 - Wheezing
R0683 - Shortness of breath
R051 - Cough due to allergies
R0689 - Other specified symptoms and signs involving the respiratory system
R0981 - Sneezing
H041 - Itching or watery eyes (allergic conjunctivitis)
R0989 - Other specified symptoms and signs involving the circulatory and respiratory systems (for nasal congestion)
L309 - Dermatitis, unspecified (for skin rashes or hives)
J329 - Chronic sinusitis, unspecified
R51 - Headache (included again for emphasis)
R4182 - Cognitive dysfunction (for difficulty concentrating or memory problems)

4 PATIENT CONSENT

I authorize ClinLGX and/or its authorized agents, to run the specified tests on my blood sample and/or nasal swab. I understand that as a courtesy, ClinLGX and/or its authorized agents will make every reasonable effort to obtain reimbursement for ordered tests. I understand that I am making an assignment of my insurance plan benefits to ClinLGX and/or its authorized agents. I also authorize the release of any information contained in my records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. Bill to my insurance: I understand that if my insurance company pays me directly for services rendered by ClinLGX, I am responsible for forwarding such payment to ClinLGX. I also understand that I am responsible for any deductible/co-payment and coinsurance, or other obligations, as required by my plan and state laws PATIENT SIGNATURE:

_____ DATE:_____

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