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."

Inhalant ID

Introducing Inhalant ID, a revolutionary health solution designed to accurately identify and manage allergens. Discover if symptoms such as running nose, stuffy nose, itchy nose, sneezing, and itchy eyes are allergy or non-allergy by evaluating IgE reactivity of 40 environmental allergens and patient specific data.

Trigger Food IgE

Gain insight into the classisfiation of adverse food reactions (food allergy or food intolerence) that may be triggered by 28 comman foods in your diet using patient-specific data and in vitro IgE testing.

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

Z91.010 Allergy to Peanuts
L27,2 Dermatitis due to ingested foods
29.70 Gastritis,unspecified
K59.00 Constipation,unspecified
R14.3 Flatulence
K90 89 Other intestinal malabsorption
L70.9 Acne, unspecified substance taken internally
Z91.012 Allergy to eggs
R19.7 Diarrhea, unspecified
J01.80 Other acute sinusitis
R53.82 Chronic fatgue, NOS
J45.32 Moderate persistent asthma w/status asthmaticus
J45.990 Exercise-induced brochospasm
J20.9 Acute bronchitis
J45.991 Cough variant asthma
J31.0 Chronic rhinitis
J30.1 Allergic rhinitis due to pollen
J01.40 Acute pansinusitis, NOW
J30.2 Other seasonal allergic rhinitis
J30.5 Allergic rhinitis due to food
J45.50 Severe persistent asthma, uncomplicated

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 lawsPATIENT SIGNATURE:

_____ DATE:_____

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