ibs-smart™ Blood Test Requisition Form

ACCOUNT#: _____

ibs•smart™

PATIENT INFORMATION

Name: _____ (First / MI / Last)

Address 1: _____

Date of Birth: _____ (mm/dd/yyyy)

Address 2: _____

Sex (Male, Female): _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____

PATIENT'S INSURANCE INFORMATION

Check one:

***PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARD.**

☐ **HMO, PPO, Commercial Insurance***

Provider: _____ Policy#: _____

Policyholder: ☐ Self ☐ Other: _____ (Relationship to Patient (e.g., "Spouse," "Parent"))

Name: _____ (Policyholder Info (if Other))

Date of Birth: _____ Sex (Male, Female): _____

☐ **Medicare / Medicaid***

Subscriber ID: _____

Authorization #: _____

☐ **Self-Pay ($220)** - Patient will be billed directly via mail.

PATIENT SIGNATURE (REQUIRED)

I authorize any physician or lab who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Pacific Diagnostics. I understand I am responsible for any co-pay or deductible amounts. I understand I am fully responsible for payment of my account if Pacific Diagnostics is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

SIGN HERE _____ **DATE** _____

PATIENT SIGNATURE

ORDERING PRESCRIBER INFORMATION

Prescriber or Clinic Account Name: _____

City: _____ State: _____ Zip: _____

(If Clinic Account) Reference Prescriber: _____

Phone: _____

Address 1: _____

DELIVER TEST RESULTS TO (*select <u>one</u>*):

Address 2: _____

☐ Email ☐ Fax _____ (Email Address *or* Fax Number)

PRESCRIBER SIGNATURE (REQUIRED)

As the referring prescriber named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, and, if required by my institution, has given informed consent.

SIGN HERE _____ **DATE** _____

PRESCRIBER SIGNATURE

ICD-10 DIAGNOSIS CODE (REQUIRED)

☐ **K58.8** (IBS)
☐ **K58.0** (IBS-D)
☐ **K58.2** (IBS-M)
☐ **K52.9** (chronic diarrhea)

Other: _____ _____ _____

LABORATORY TEST ORDERED

☒ **ibs-smart™** - CPT codes 83520 Anti-CdtB; 83520 Anti-vinculin

PacificDx

Laboratory Director: Shelly Gunn, MD, PhD

The ibs-smart™ test is conducted at PacificDx Laboratories.
5 Mason, Suite 100, Irvine, CA 92618
For questions, contact support@ibssmart.com.

SAMPLE COLLECTION INFORMATION

☐ **Whole Blood, EDTA (Lavender Top), >2mL**

All other specimens will be rejected. No pour-offs accepted.
Fasting and/or changes to current medications are **NOT** *required prior to blood draw.*

Collection Date: _____ (mm/dd/yyyy) Time: _____ (24-hr (HH:mm))

Requisition completed by: _____

RECEIVING LAB USE ONLY

Received Date/Time/Tech:

[Accession Label]

ibs-smart™ Blood Test
INSTRUCTIONS

ibs-smart™

TEST INFORMATION

ibs-smart™ is a doctor-ordered diagnostic blood test that measures the levels of two antibodies, **anti-CdtB** and **anti-vinculin**, known to be elevated in patients with IBS with a diarrheal component (IBS-D or IBS-M) that was caused by an infection (food poisoning).

ibs-smart™ costs **$220** and is covered at least in part by many common insurance plans. A claim is filed on your behalf, and patients with private insurance plans are responsible for the balance not covered by insurance. **There is no cost for the test for Medicare patients.**You can inquire with your insurance company about anticipated coverage by providing the **CPT code: 83520**, which is billed twice (once for each antibody).

FOR PATIENTS

If your healthcare provider has determined that ibs-smart™ is right for you, please use the following steps to receive a testing kit that may be taken to your local blood draw center:

1. Please visit **www.ibssmart.com/patientkit.**
2. Using the signed test requisition form (reverse side) provided by your doctor, please complete the online form to have an ibs-smart™ testing kit mailed to your home.
3. Bring your testing kit and the signed test requisition form to a local blood draw center, so that your sample (and the test requisition form) can be shipped to our lab for testing. Local blood draw centers can be found at **www.ibssmart.com/blooddraw.**
4. Samples can be dropped off at any FedEx drop box location, which may be found at **www.local.fedex.com.**
5. The test results will be sent directly to your healthcare provider in approximately 4 days, so that you may discuss the best steps for treatment.

Should you have any questions about ibs-smart™ or if you have any difficulty finding a blood draw lab, please contact our Patient Care team at **patientcare@ibssmart.com** or visit **ibssmart.com** for more information.

FOR PRESCRIBERS

If you have determined that ibs-smart™ is right for your patient, ordering is easy:

1. Testing kits with phlebotomy materials can be provided to you at no cost by visiting **www.ibssmart.com/order.**
2. If you do not draw blood or would prefer not to store testing kits in your office, provide a signed copy of the test requisition form (reverse side) to your patient. Patients may use the above instructions to request a testing kit be sent to their home at no cost. We will direct patients to local blooddraw labs for samples collection.
3. The test results will be sent directly to you approximately 4 days after receiving the sample.

Should you have any questions about the ibs-smart™ ordering process, please contact our Customer Support team at **support@ibssmart.com.**