ibs-smart Blood Test Requisition Form

ACCOUNT#: ______________________

ibs•smart®
Fax requisition to: (888) 675-9961
Questions? support@ibssmart.com

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"))

Policyholder Name: ______________________ (Policyholder Info (if Other))

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

☐ **Medicare / Medicaid***

Subscriber ID: ______________________

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

An insurance claim for **$220** will be filed on the patient's behalf. Patients with private insurance will be billed the balance of the cost not covered by insurance. Patients with Medicare or Medicaid will be billed copays or coinsurance, if applicable.

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 for any reason.

SIGN HERE ______________________ **DATE** ______________

PATIENT SIGNATURE

ORDERING PRESCRIBER INFORMATION

Prescriber or Clinic Account Name: ______________________

Address 1: ______________________

(If Clinic Account) Reference Prescriber: ______________________

Address 2: ______________________

NPI: ______________________

City: ______________ State: ______ Zip: ______

DELIVER TEST RESULTS TO: ______________________
Enter Email Address or Fax Number

Phone: ______________________

PRESCRIBER SIGNATURE (REQUIRED)

As the ordering 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** - PLA Code: 0164U

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]

PacificDx

Laboratory Director: Shelly Gunn, MD, PhD

© 2013-19 Pacific Diagnostics

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