

PRESCRIBER #: _____

For Lab Use Only

PATIENT INFORMATION

Name: _____ Address 1: _____
First MI Last Note: We cannot ship to PO Boxes

Date of Birth: _____ Address 2: _____
mm/dd/yyyy

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* **Medicare / Medicaid***

Provider: _____ Policy #: _____ Subscriber ID: _____

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

Cash Pay (\$349) - Patient will be billed directly via mail.

Name: _____
Policyholder Info (if Other)

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

An insurance claim for **\$349** will be filed on the patient's behalf. Patients with private insurance will be billed the balance of the test not covered by insurance. Patients with public insurance (Medicare and Medicaid) will not be billed any balance other than co-pays or co-insurances (if applicable).

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.

PATIENT SIGNATURE (REQUIRED)



SIGN HERE

 PATIENT SIGNATURE

DATE _____

ORDERING PRESCRIBER INFORMATION

Practice Name: _____ Address 1: _____

Prescriber Name: _____ Address 2: _____

NPI: _____ City: _____ State: _____ Zip: _____

DELIVER TEST RESULTS TO: _____ Phone: _____
Enter Email Address or Fax Number

LABORATORY TEST ORDERED

trio-smart CPT code: 91065

Substrate (REQUIRED): _____

PacificDx

5 Mason, Suite 100, Irvine, CA 92618
 Laboratory Director: Elizabeth S Gunn, MD, PhD

gemelli biotech

2450 W Broadway Rd, Ste 120, Mesa, AZ 85202
 Laboratory Director: Boaz Kurtis, MD

SUBSTRATE RX

If you have ordered a lactulose breath test, **please provide your patient with a prescription** for one dose of **10gm/15ml solution of lactulose**.

If you have ordered a glucose breath test, one dose of **75gm solution of glucose** will be **included in the sample collection kit**.

ICD-10 DIAGNOSIS CODE (REQUIRED)

- R14.3** (Flatulence) **R14.0** (Abdominal Distension) **R14.2** (Eructation) **R10.9** (Abdominal pain) **K58.8** (IBS) **K58.0** (IBS-D) **K58.2** (IBS-M) **K58.1** (IBS with Constipation)

Other: _____

PRESCRIBER SIGNATURE (REQUIRED)



SIGN HERE

 PRESCRIBER SIGNATURE

DATE _____