trio-smart Breath Test Requisition Form

trio-smart®

Fax requisition to: (818) 301-3222
Questions? support@triosmartbreath.com

PRESCRIBER #: ____________________
For Lab Use Only

PATIENT INFORMATION

Name: ______________________________ (First / MI / Last)

Address 1: ______________________________
Note: We cannot ship to PO Boxes

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: ______________________________

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

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).

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 Gemelli Biotech. I understand I am responsible for any co-pay or deductible amounts. I understand I am fully responsible for payment of my account if Gemelli Biotech 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

Practice Name: ______________________________

Prescriber Name: ______________________________

NPI: ______________________________

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

Address 1: ______________________________

Address 2: ______________________________

City: ______________ State: ______ Zip: ______

Phone: ______________________________

LABORATORY TEST ORDERED

Please select **only one** of the following:

☐ **trio-smart** - LACTULOSE *Please provide your patient with a prescription for one dose of 10gm/15ml solution of lactulose.

☐ **trio-smart** - GLUCOSE

☐ **trio-smart malabsorption** - LACTOSE

☐ **trio-smart malabsorption** - FRUCTOSE

☐ **trio-smart malabsorption** - SUCROSE

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

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)
☐ **K58.9** (IBS with no diarrhea)
☐ **K90.9** (Intestinal Malabsorption, unspecified)
☐ **K90.49** (Malabsorption due to intolerance)
☐ **E739** (Lactose intolerance unspecified)
☐ **E74.31** (Sucrase-isomaltase deficiency)
☐ **E74.12** (Hereditary fructose intolerance)

Other: ______________________________

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