

ACCOUNT#: _____

PATIENT INFORMATION

Name: _____ Address 1: _____
First MI Last

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")

Name: _____ Policyholder Info (if Other)

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

Cash Pay (\$289) - Patient will be billed directly via mail.

An insurance claim for \$289 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.

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

Prescriber or Clinic Account Name: _____ Address 1: _____

(If Clinic Account) Reference Prescriber: _____ 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): _____
Lactulose or Glucose



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

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)
- K58.9 (IBS with no diarrhea)

Other: _____

PRESCRIBER SIGNATURE (REQUIRED)



SIGN HERE

PRESCRIBER SIGNATURE

DATE _____