

ibs-smart Blood Test Requisition Form

PRESCRIBER#: _____

For Lab Use Only

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: _____ **Cash Pay (\$220)** - Patient will be billed directly via mail.
Relationship to Patient (e.g., "Spouse," "Parent")

Policyholder Name: _____
Policyholder Info (if Other)

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

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)



SIGN HERE

PATIENT SIGNATURE

DATE _____

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.

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

PRESCRIBER SIGNATURE (REQUIRED)



SIGN HERE

PRESCRIBER SIGNATURE

DATE _____

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.

ICD-10 DIAGNOSIS CODE (REQUIRED)

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

Other: _____

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

Requisition completed by: _____

LABORATORY TEST ORDERED

ibs-smart - PLA Code: 0164U

PacificDx

Laboratory Director: Elizabeth S 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.

RECEIVING LAB USE ONLY

Received Date/Time/Tech: _____

[Accession Label]