Trio-Smart Breath Test Requisition Form

PRESCRIBER #: ____________________
For Lab Use Only

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

PATIENT INFORMATION

Name: ______________________________
First MI Last

Date of Birth: ______________________
mm/dd/yyyy

Sex (Male, Female): ______________________

Email: ______________________________

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

Address 2: ______________________________

City: ______________ State: ______ Zip: ________

Phone: ______________________________

PATIENT'S INSURANCE INFORMATION

Check one box (1, 2, or 3):

PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARD.

1 ☐ **HMO, PPO, Commercial Insurance***

Insurance Provider: ______________________

Group #: ______________________

Policy ID: ______________________

Policyholder Name: ______________________

2 ☐ **Medicare / Medicaid***

Medicare # or Medicaid ID: ______________ Plan Name: ______________

3 ☐ **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).

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.

PATIENT SIGN HERE ______________________ **DATE** ______________ **DATE OF COLLECTION** ______________
(REQUIRED)

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 **one** of the following (**mandatory**):

☐ **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)

☐ **R10.9** (Abdominal Pain)
☐ **R11.0** (Nausea)
☐ **R14.0** (Abdominal Distension)
☐ **R14.1** (Gas Pain)
☐ **R14.2** (Eructation)
☐ **R14.3** (Flatulence)
☐ **R19.7** (Diarrhea)
☐ **K59.00** (Constipation)

Other: ______________________

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.

PRESCRIBER SIGN HERE ______________________ **DATE** ______________
(REQUIRED)