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)

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 ($319)** - Patient will be billed directly via mail.

An insurance claim for **$319** 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 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.

SIGN HERE _____ **DATE** _____
PATIENT SIGNATURE

ORDERING PRESCRIBER INFORMATION

Practice Name: _____

Address 1: _____

Prescriber Name: _____

Address 2: _____

NPI: _____

City: _____ State: _____ Zip: _____

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

Phone: _____

LABORATORY TEST ORDERED

☒ **trio-smart** CPT code: 91065

Substrate (REQUIRED): _____
Lactulose or Glucose

PacificDx
5 Mason, Suite 100, Irvine, CA 92618
Laboratory Director: Elizabeth S 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)

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