trio-smart Breath Test Requisition Form

ACCOUNT#: _____

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

PATIENT INFORMATION

Name: _____ (First / MI / Last)
Address 1: _____

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 ($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 test not covered by insurance. Patients with public insurance (Medicare and Medicaid) will not be billed any balance.

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

Prescriber or Clinic Account Name: _____
Address 1: _____

(If Clinic Account) Reference Prescriber: _____
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: 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)

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