IBS*chek*® By Commonwealth Diagnostics International, Inc.

Barcode

BLOOD TEST
LABORATORY REQUISITION FORM

Patient Note: The "Providers Information" section does **not** need to be completed if your kit was shipped directly to you by CDI.

Test Information (*Not available in NY*)

Test Request (check all that apply) $99 per Test:

☐ IBS*chek*® (anti-CdtB and anti-vinculin)

Sample Type: *EDTA Whole Blood/Plasma*

ICD-10 Code: (REQUIRED TO PROCESS)

□ K58.0 (Irritable Bowel Syndrome w/ diarrhea)*

□ Other(s) _____

*These codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describe the reason for performing the test, regardless of whether the code is listed above or not.

Provider Information

Practice Name | Provider Name | NPI # *(Required, US only)*

Address | City | State/Prov. | Zip/Post. | Country

Provider Phone #

Provider Email

Provider Signature (REQUIRED) | Date

Patient Information

First Name | Last Name | Date of Birth | Sex: (circle one) M F

Address | City | State/Prov. | Zip/Post. | Country

Phone # | Email (Please provide patient email address to receive important information and status updates regarding this test)

CDI does not currently accept any Medicaid plans

Please select how you would like your test to be billed: (REQUIRED TO PROCESS)

☐ I would like CDI to submit a claim to my insurance and I will provide copies of my insurance card(s) (**front and back**) by one of the following:

- ☐ Attach photocopies returned with this requisition form
- ☐ E-mail a photo to insurance@commdx.com (please include the barcode number at the top of this form with your e-mail which starts with "DX")
- ☐ Call customer service at 888-258-5966 to provide the information

Name of Insured (*if not patient*) | Relation | Date of Birth

☐ I elect to self-pay $99 for my test and have provided my credit card information or attached a check made payable to Commonwealth Diagnostics International, Inc.

Credit Card/Debit Card #

Exp. | Zip (if different from above)

By providing my credit card information I authorize CDI to charge me for any balance remaining after insurance processes my claim or if CDI does not hear back from insurance in a timely manner.

IMPORTANT INSURANCE & PAYMENT INFORMATION

By signing this requisition form, I authorize the release of any medical information necessary to my insurance company and the payment of benefits to Commonwealth Diagnostics International, Inc. ("CDI") for products and services received. I authorize the release of information to the listed provider(s) and/or individual(s) named on this form.

- I understand that CDI will submit a claim on my behalf to commercial insurance, Medicare or Tricare.
- I understand my insurance may cover some or all of the test depending on my insurance plan and benefits and my out-of-pocket cost can be limited to $99 if paid promptly.
- I understand that in the event my insurance provider denies my insurance claim, or if I have not met my deductible or have a coinsurance or co-pay, or for any reason does not cover the full amount of the test, I am responsible to pay CDI for products and services received.
- If I receive payment directly from my insurance carrier, I will forward that payment and a copy of my Explanation of Benefits (EOB) to CDI or I will remit a personal check to CDI for the amount sent to me by my insurance carrier for CDI's service.
- I understand that CDI does not accept any Medicaid plans, and if I am a Medicaid patient taking a test, I will be responsible for the full cost of the test prior to receiving results.
- I understand that CDI will not be able to report results until all of the information listed as "required" on this form has been provided.

CDI offers convenient payment plans and financial hardship programs for qualifying patients. Patients may pay up front via check sent with the kit or credit card by calling CDI's Billing Department. For all billing related questions, please contact 888-258-5966 or customerservice@commdx.com. For an updated list of in-network providers, please visit **commdx.com/insurance**.

Blood Samples will be Subject to REJECTION if:

- The blood sample is coagulated, grossly hemolyzed, or contains high lipid content
- Shipping instructions were not followed
- The blood sample arrives without two (2) unique identifiers
- The blood sample arrives with less than 500µl (not enough sample)

Patient Signature (REQUIRED TO PROCESS) | Date | Date of Specimen Collection (REQUIRED TO PROCESS)

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