Commonwealth Diagnostics International INC.

Barcode

BREATH TEST
LABORATORY REQUISITION FORM

PROVIDER NOTE: *PLEASE FAX OR EMAIL COPIES OF ALL PATIENT INSURANCE CARDS (FRONT AND BACK), DEMOGRAPHIC SHEETS, AND THIS FORM TO CDI AT THE TIME YOU HAND OUT THE TEST KIT AND PROVIDE COPIES TO PATIENT.*

PATIENT NOTE: *THE "PROVIDER INFORMATION" SECTION DOES NOT NEED TO BE COMPLETED IF YOUR TEST KIT WAS SHIPPED DIRECTLY TO YOU BY CDI.*

Provider Information (to be completed by Provider)

Provider Name | Provider NPI #

Provider Signature **(REQUIRED TO PROCESS)** | Date

Address | City | State | Zip

Practice Name | Phone

Email | Fax

ICD-10 Code **(REQUIRED TO PROCESS)**

- ☐ R10.84 Generalized abdominal pain
- ☐ R14.0 Abdominal distension (gaseous)
- ☐ R19.7 Diarrhea, unspecified
- ☐ K59.0 Constipation
- ☐ K58.0 Irritable bowel syndrome with diarrhea
- ☐ A04.9 Bacterial intestinal infection, unspecified
- ☐ _____ Other

Test Type *(check one)*

- ☐ SIBO 10 Tube Lactulose
- ☐ SIBO 10 Tube Glucose
- ☐ SIBO 6 Tube Lactulose (pediatric use)
- ☐ Sucrose 6 Tube
- ☐ Lactose 6 Tube
- ☐ Fructose 6 Tube

Patient Information

First Name | Last Name | Date of Birth

Sex: ☐ Male ☐ Female

Full Address | Apt. # | City | State | Zip

Phone # | Email

Please provide patient email address to receive important information and status updates regarding this test.

BILLABLE INSURANCE OR PAYMENT INFORMATION **(REQUIRED TO PROCESS)**

Please select how you would like your test to be billed:

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

NOTE: CDI **does not** current accept any Medicaid plans.

- ☐ 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 $199 for my test and have provided my credit card information below 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 TERMS

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 $199 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 max out-of-pocket 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.
- I understand that I may be billed for the maximum out-of-pocket cost per test kit if I fail to follow all instructions properly leading to an invalid test result. If i receive an invalid result, I can receive a second complimentary test kit free of charge after providing payment for the max out-of-pocket cost for the first test kit.

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**.

Patient Signature **(REQUIRED TO PROCESS)** | Date | Date of Test **(REQUIRED TO PROCESS)**