

FUNCTIONAL GI DIAGNOSTIC SOLUTIONS

SAMPLE COLLECTION KIT ORDER FORM



COMMONWEALTH
DIAGNOSTICS
INTERNATIONAL

PROVIDER NOTE: PLEASE SEND THIS COMPLETED FORM BY FAX (888) 258-5973 OR EMAIL INFO@COMMDX.COM

Provider/Practice Information			
Provider Name <i>(REQUIRED TO PROCESS)</i>		NPI #	
<div style="border: 1px solid black; height: 30px; width: 100%;"></div>			
Provider Signature* <i>(REQUIRED TO PROCESS)</i>		Date	
Address	City	State	Zip
Practice Name		Email	
Phone		Fax	
Please send results via: <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Web Portal			
Sample Collection Kit		Quantity	
Breath Tests			
<input type="checkbox"/>	SIBO 10 Tube Lactulose	_____	
<input type="checkbox"/>	SIBO 10 Tube Glucose	_____	
<input type="checkbox"/>	SIBO 6 Tube Lactulose (pediatric use)	_____	
<input type="checkbox"/>	Lactose 6 Tube	_____	
<input type="checkbox"/>	Fructose 6 Tube	_____	
<input type="checkbox"/>	Sucrose 6 Tube	_____	

*By signing this order form, the ordering practice represents that it has the appropriate prescribing rights to order the tests selected on this form.

PLEASE CHECK THIS BOX WHEN SHIPPING DIRECTLY TO A PATIENT *(INFORMATION BELOW REQUIRED WHEN CHECKED)*

Patient Information			
First Name		Last Name	
Date of Birth			
Full Address			Apt. #
City	State	Zip	
Phone #			
Email <i>(Please provide patient email address to receive important information and status updates regarding this test)</i>			
ICD-10 Code for Breath Tests			
<input type="checkbox"/> R10.84 Generalized abdominal pain			
<input type="checkbox"/> R14.0 Abdominal distension (gaseous)			
<input type="checkbox"/> R19.7 Diarrhea, unspecified			
<input type="checkbox"/> K59.0 Constipation			
<input type="checkbox"/> K58.0 Irritable bowel syndrome with diarrhea			
<input type="checkbox"/> K63.8211 SIBO, hydrogen subtype			
<input type="checkbox"/> K63.8219 SIBO, unspecified cases			
<input type="checkbox"/> K63.829 Intestinal Methanogen Overgrowth (IMO)			
<input type="checkbox"/> E73.9 Lactose intolerance, unspecified			
<input type="checkbox"/> E74.31 Sucrase-isomaltase deficiency			
<input type="checkbox"/> E74.12 Hereditary fructose intolerance			
<input type="checkbox"/> _____ Other			

IMPORTANT INSURANCE & PAYMENT INFORMATION

CDI will submit a claim on the patient's behalf to commercial insurance, Medicare or Tricare. Insurance may cover some or all of the test depending on the patient's insurance plan and benefits. In the event the patient's insurance provider denies the insurance claim, or if the patient has not met the deductible or has a coinsurance or co-pay, or if for any reason the insurance does not cover the full amount of the test, the patient is responsible to pay CDI for products and services received.

CDI does not accept any Medicaid plans: therefore any Medicaid patient taking a test will be responsible for the full cost of the test. CDI offers convenient payment plans and financial hardship programs for qualifying patients. Patients may pay upfront via check sent with the kit or credit card. The maximum out-of-pocket cost is \$249 per breath test for patients that pay promptly in accordance with CDI patient billing policies and programs. For an updated list of in-network providers, please visit commdx.com/insurance.