Two-Sided Form - Please Review and Ensure both sides are completed. Insurance & Billing fields below and Patient Information on back are required.

COMMONWEALTH DIAGNOSTICS INTERNATIONAL

Barcode

BREATH TEST
LABORATORY REQUISITION FORM

PROVIDER NOTE: PLEASE FAX OR EMAIL THE FOLLOWING TO CDI AT THE TIME YOU HAND OUT THE TEST KIT AND PROVIDE COPIES TO PATIENT:

- *COPIES OF ALL PATIENT INSURANCE CARDS (FRONT AND BACK)*
- *DEMOGRAPHIC SHEETS*
- *THIS COMPLETED FORM*

Provider Information (Must be completed by Provider if handing out kit in office. If mailed to patient home, this section only may be left blank.)

Provider Name: First Name | Last Name | Provider NPI #

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

Street 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
- ☐ K63.8211 SIBO, hydrogen subtype
- ☐ K63.8219 SIBO, unspecified cases
- ☐ K63.829 Intestinal Methanogen Overgrowth (IMO)
- ☐ _____ 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

IMPORTANT INSURANCE, PAYMENT, & RELEASE 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. By taking and returning a CDI breath test, I acknowledge agreement to all terms below:

- **I understand that CDI will submit a claim on my behalf to commercial insurance, Medicare, or Tricare in the amount of $699, and that it is my responsibility to contact them beforehand to determine coverage and eligibility.**
- 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 $299 if paid promptly.
- I understand that in the event my insurance provider denies my insurance claim, 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 in the amount of $299.
- 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. This amount does not count toward the patient responsibility.
- **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 **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 test kit free of charge after providing payment for the max out-of-pocket cost for the first test kit.
- I understand that although samples are always processed on arrival, CDI will not be able to release the result report until all of the information listed as "required" on this form has been provided.
- **CDI offers convenient payment plans and financial assistance programs for qualifying patients.** The financial assistance form is available here: https://commdx.com/insurance/. Patients may pay up front via check sent with the kit or by credit card.
- I understand that once a test kit has been completed and dropped off for return shipping it will be processed and billed upon arrival at CDI's laboratory. **A test cannot be cancelled once it has been sent back.**
- I confirm that I have read, understand, and agree to abide by CDI's Terms of Service (https://commdx.com/terms/) and Privacy Policy (https://commdx.com/privacy/). I consent to the collection, use, and processing of my personal information in accordance with the Privacy Policy.
- I consent to receiving communication via email, SMS, and/or phone call for patient support purposes from CDI. I understand that I can unsubscribe from these communications at any time by contacting CDI or by using the unsubscribe link provided in the messages.

HIPAA Compliant Release of Records - I acknowledge agreement to release a copy of my test results to me, the patient or parent/guardian, directly. I understand that if I fail to complete these steps, I will need to complete the release process separately to have a copy of the report sent to me directly.

Choose Option & Method Below:

- ☐ I understand that HIPAA regulations recommend encrypting PHI for my privacy and safety. By checking this box, I agree to receive my results as an encrypted PDF, fax, or physical mail.
- ☐ I understand that HIPAA regulations recommend encrypting PHI for my privacy and safety. I am requesting that my results be sent via unencrypted PDF and I accept the risks and responsibilities associated with waiving encryption.

Method of Sharing Result Report with Patient: ☐ Email ☐ Fax ☐ Mailing Address **I have provided a copy of a signed photo ID:** ☐

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.**

Print Patient Name

Print Parent or Guardian Name if Applicable

Patient or Parent/Guardian Signature **(REQUIRED TO PROCESS)**

Date of Service (Date Samples are Collected) **(REQUIRED TO PROCESS)** M M — D D — Y Y Y Y

4 Technology Way Salem, MA 01970 USA
P:+1(888) 258-5966 F:+1(888) 258-5973
info@commdx.com
www.CommDX.com

CPT Code for SIBO and malabsorption breath tests: 91065 x2
Billed at $699.00 to insurance.
NPI: 1831625342
Tax ID: 47-4725769

COMMONWEALTH DIAGNOSTICS INTERNATIONAL

BREATH TEST
LABORATORY REQUISITION FORM

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

Patient Information (ALL PATIENT INFORMATION IS REQUIRED TO PROCESS)

First Name* _____ Last Name* _____

Sex: ☐ Male ☐ Female

Name as it Appears on Insurance Card: First Name _____ Last Name _____ Patient Date of Birth* MM – DD – YYYY

Street Address* _____ Apt. # _____ City* _____ State* _____ Zip* _____

Phone #* _____ Email _____

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

BILLABLE INSURANCE & PAYMENT INFORMATION (REQUIRED TO PROCESS)

STEP ONE: Provide Credit/Debit Card Information
Required regardless of option selected in Step Two

Name on the Card

Credit Card/Debit Card #:

Exp. MM – YY CVV (3 or 4 digit) Zip (if different from above)

STEP TWO: 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.
NOTE: CDI does not currently accept any Medicaid plans. If you provide a Medicaid or state funded plan, we will bill the **CC info provided**, or reporting will be delayed until payment is received. CDI does not check insurance coverage prior to billing, patients are responsible for checking coverage prior to testing.

Send Insurance card copies by:
- Attaching photocopies to this requisition form in the Insurance Plan Information section below when returning your test.
- E-mailing photos to insurance@commdx.com. **Include the barcode number of your test (which starts with "DX" followed by 6-digits), your name, and your date of birth.**

☐ **I elect to self-pay $299 for my test** and have provided my credit card information here or attached a check made payable to Commonwealth Diagnostics International, Inc.
If you check this box and do not provide payment information, reporting will be delayed until we receive payment.
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 in a timely manner.

Insurance Plan Information

CDI will submit a claim on my behalf to commercial insurance plans, Medicare, or Tricare in the amount of $699, **it is my responsibility** to contact them beforehand to determine coverage and eligibility. CDI does not submit claims to Medicaid or any state-funded plans. If your insurance plan is Medicaid/state-funded, you are responsible for the cost of the test. Any test performed and shipped to the CDI lab will be processed and billed.

Please provide the applicable plan information in the boxes below if unable to attach copies.
If you need assistance, please contact our Customer Service team at customerservice@commdx.com or 888-258-5966.

Guarantor Information (If Applicable)
Guarantor First Name * _____ Guarantor Last Name * _____ Guarantor Date of Birth * MM – DD – YYYY

Primary Insurance Plan Information

Primary Insurance Company: _____
Plan Name: _____
Primary Insurance ID: _____
Primary Insurance Group: _____
Primary Insurance Payer ID: _____
Provider or Customer Service Phone: ___-___-____
Claims Address: _____

Secondary Insurance Plan Information

Secondary Insurance Company: _____
Plan Name: _____
Secondary Insurance ID: _____
Secondary Insurance Group: _____
Secondary Insurance Payer ID: _____
Provider or Customer Service Phone: ___-___-____
Claims Address: _____

Test Notes

If anything out of the ordinary occurs during testing, adverse effects, known errors, etc, notes to the lab may be left below:

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CPT Code for SIBO and malabsorption breath tests: 91065 x2
Billed at $699.00 to insurance.
NPI: 1831625342
Tax ID: 47-4725769