Requisition Form Sample

Please check either **Patient Insurance** or **Payment Enclosed**

"Account # 24956"

"Physicians Signature"
Print the following…
Signature On File

Fill out ALL patient information.
EXCEPT for child's SS#

Prepayment does not require insurance info

REQUISITION FORM

DOCTOR'S DATA INC
3755 Illinois Avenue • St. Charles, IL 60174-2420
800.323.2784 • 630.377.8139 • Fax 630.587.7860
inquiries@doctorsdata.com • www.doctorsdata.com

Note: *This form must be completed and signed by both the physician and the financially responsible party in order to avoid processing delays.*

1 Bill to (select one):

- ❑ ~~Physician Account (N/A in NY or NJ) – Complete 1,2,3,4~~
  ~~(If nothing is selected, physician account will be billed)~~
- ❑ Patient – Complete Sections 1,2,3,4
- ❑ Patient Insurance – Complete Sections 1,2,3,4,6
- ❑ Medicare – Complete Sections 1,2,3,4,6,7
- ❑ Payment Enclosed – Complete Sections 1,2,3,4,5

2 Physician Information

❑ *New Client? Address change? Incorrect physician listed below? Check here and indicate correct information on reverse side.*

Account #: ____________

Physician Name: ____________ Degree: ______

Clinic Name: ____________

Address: ____________

City: ____________ State: ______ ZIP: ______

Physician Signature:

X *(Required)* ____________ Date Ordered: ______

NPI # ____________

Medicare will pay only for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Medicare does not pay for tests for which documentation, including the patient record, does not support that the tests were reasonable and necessary. Medicare generally does not cover routine screening tests even if the physician or other authorized test orderer considers the tests appropriate for the patient. Your ordering of the test(s) means that you believe the test(s) is medically necessary unless you indicate that it is for screening purposes.

3 Test(s) Ordered *Medicare patients: see reverse side for important information.*

For insurance/Medicare provide ICD-9 diagnosis codes for each test ordered.

❒ **Fecal Metals profile**

Date final sample was collected: ___/___/___ X

Collection Information:

If this sample is part of a provocative challenge; is it ❑ pre or ❑ post?

Provoking agent: ______ Dosage: ______

Does the patient have dental amalgams? Yes No: If yes, how many? ______

Profile components:	CPT:	ICD-9 Diagnosis Codes (required):		
Heavy Metals; Antimony, Beryllium, Bismuth, Platinum, Thallium, Tungsten, Uranium	83018	985.9		
Arsenic	82175			
Cadmium	82300			
Copper	82525			
Lead	83655			
Mercury	83825			
Nickel	83885			

Medicare patients must read and sign the back of this form.

Patient Information

(Please print clearly) *All information is necessary for lab analysis and will be kept confidential. Patient/responsible party is financially responsible for any portion of the claim not covered by insurance within 60 days.*

Date Final Sample Collected: ___/___/___

Patient Last Name: ____________ **First Name:** ____________

Patient Date of Birth: ___/___/___ ❑ **Male** ❑ **Female** Patient Social Security #: ___-___-___

Mailing Address: ____________ City: ____________ State: ______ Zip: ______

Daytime Phone:(_____) ____________ Evening Phone:(_____) ____________ Email Address: ____________

Responsible Party Name: ____________ Responsible Party Social Security #: ___-___-___

Mailing Address: ____________ City: ____________ State: ______ Zip: ______

Patient/Responsible Party Signature *I permit a copy of this requisition to be used in place of the original. If Insurance does not provide coverage, I agree to be personally and fully responsible for payment. Except in the case of prepayment, I authorize payment of all medical benefits to be paid directly to Great Smokies Diagnostic Laboratory and authorize the release of any medical information necessary for this insurance claim. For Medicare, please refer to the Advanced Beneficiary Notice (ABN), if applicable. For any questions regarding Medicare billing, consult your healthcare provider.* **X** *(Required)* ____________

Insurance Information

(Please print clearly) ***Medicare, Medicaid and Blue Cross Blue Shield patients: see reverse side for important information.***
Fill out ***only*** if you intend for Great Smokies to file a claim on your behalf. Discounted price may apply if you enclose payment in full and file your own insurance claim. It is your responsibility to verify insurance coverage. GSDL does not guarantee insurance coverage. Please call your insurance company, referring to the provided CPT code listed above for preauthorization, referral, and/or benefit verification. Please attach a copy of both sides of your insurance card.

	Primary	Secondary
Insurance Company:		
Claims Address:		
City/State/Zip:		
Phone #:	(_____)	(_____)
Subscriber Name:		
Subscriber ID #/Medicare #:		
Group #:		
Relation to Patient:	❑ Self ❑ Spouse ❑ Other	❑ Self ❑ Spouse ❑ Other
Subscriber Date of Birth:	___/___/___	___/___/___

Check or Credit Card Information

Medicare, Medicaid and Blue Cross/Blue Shield patients: see reverse side for important information.
Please do not send cash. Discounted price may apply if you enclose payment in full. A receipt will be provided which can be used to file your own insurance claim.

Payment provided: $ ______ ❑ Credit Card *(see right)* ❑ Check *(see below)*

Check from: ❑ Patient ❑ Physician

Check #: ______
*(make checks payable in U.S. dollars to **GSDL**)*

Credit Card from: ❑ Patient ❑ Physician ❑ Physician card on file

Select one: ❑ Visa ❑ MasterCard ❑ AMEX ❑ Discover

Credit Card #: ____________ Expiration Date: ___/___

Cardholder Signature: ____________ Printed Name: ____________

Cardholder Address: ____________

City: ____________ State: ______ Zip: ______

Any questions about the test or for more instructions.
Please call Doctors Data at:
1-800-323-2784

Fill in the date final sample was collected

Fill in the diagnostic code
985.9 /   /

Fill in only if you are submitting to insurance

We cannot guarantee coverage.
It is your responsibility to contact your insurance company.