

Peptide Requisition Help



TEST REQUEST FORM

THE GREAT PLAINS LABORATORY, INC.
for Health, Metabolism, and Nutrition
11813 W. 77th St. Phone 913 341-8949
Lenexa, KS 66214 Fax 913 341-6207 2/03

Patient Information

PLEASE PRINT CLEARLY

Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Email address _____

Age _____ Sex _____ Date of birth _____
Type of Specimen: urine serum stool hair
Date of Collection _____ Time _____ a.m. p.m.

Method of Payment

Bill Insurance I am enclosing 20% prepayment by check credit card
 Bill Physician
 Bill Medicare Bill Medicaid (ONLY Patients in the states of: AK, AZ, IA, KS, ME, MO, MT, and WY)
Medicare/Medicaid number: _____ (patient Medicare/Medicaid number)
 Payment in Full check or money order
 Bill credit card _____ Print name as it appears on credit card
Via MC/AmX/Dis# _____ Expiration Date _____

Insurance Information

We cannot bill Blue Cross/Blue Shield or any of its related groups (if you have this insurance carrier you must pay in full by check or credit card).

Please An insurance form for reimbursement will be sent to you when payment by check, money order, or credit card is received.
A copy of your insurance card and a 20% prepayment of the total insurance amount must accompany this requisition.

Your prepayment will be refunded if the insurance pays in full and there is no outstanding balance due. Send both Primary & Secondary insurance information.

Company Name _____ Primary Insurance
Ins. Co. Address _____
City, State, Zip code _____
Ins. Co. Phone (Required) _____
Name of Insured _____
Ins. Subscriber # _____
Group # _____
Patient Relationship to Insured: Self Child Other

I have a second health insurance plan.

I authorize payment of all medical benefits to be paid directly to The Great Plains Laboratory, Inc. I also understand that I will be held responsible for any portion of the claim not covered by insurance. I authorize any holder of medical information about me to release any information necessary for this claim. I permit a copy of this to be used in place of the original.

Physician Signature Required _____

Physician

Physician Name _____ UPIN _____
Institution _____
Address _____
City, state, Zip code _____
Physician Phone _____
Physician Fax _____

Physician Signature

Type of test

U/MINE Specimen Requirements on Blank
 Full organic acid test profile (OAT)
 Microbial OAT profile (included in full organic acid test profile)
 Peptide test for gluten & casein
 Lactose Acid Panel (LAP)
 Uric Acid Random Collection 24 hour total volume _____ mls
 Succinylacetone (succinyl test)
 Salivary
 Methab urine (M) Type of collection: (A) 24hr (B) Timed; # of hrs _____ total volume _____ mls (C) Random
 Post-Prandial _____

SP/DL/U/MINE

COMBO Organic acid test + Yeast C&S
 COMBO Microbial OAT + Yeast C&S
 Yeast Culture w/Sensibility (yeast C&S)
 Comprehensive Stool Analysis
 Methab Fecal (M) Pre or Post-Prandial _____
 Does the patient have dental amalgam? Yes No How many? _____

BLOOD/HAIR

DPP IV (dipeptidyl peptidase IV)
 Essential Fatty Acid Profile (EF)
 Food Allergy (Comprehensive 96 - IgG)
 Glial Fibrillary Acid Protein
 Myelin Basic Protein
 Inhaled Allergy (Basic 10 - IgE)
 Inhaled Allergy (Comprehensive 22 - IgE)
 Immune Deficiency Panel
 IgG subclasses (included in immune deficiency panel)
 Metal Profile hair blood
 Salivary
 Trans-glutaminase antibodies (test for celiac disease)
 Vitamin Panel (12 test)
 Vitamin Panel (28 test)
 Zinc (included in immune deficiency panel)
 Other _____

Diagnostic Codes Requested by Insurance Reimbursements.

(ICD-9 Codes)

Check any of the following that apply (not require but may be helpful in explaining results)
____ Alcohol's _____ Cerebral Dis. _____ Dementia _____ OCD
____ ADD/ADHD _____ Chronic fatigue _____ Fibromyalgia _____ PDD
____ Asperger's _____ Colon _____ Irritable bowel _____ Psychosis
____ Autistic symptoms _____ Depression _____ Lethargy _____ Schizophrenia
____ Autoimmune Dis. _____ Dermatitis _____ Mental retardation _____ Seizures
____ Galac _____ Diabetes _____ MS _____ Trauma's
Other _____

Person Responsible for Charges

Fill out the following if person responsible for charges is different than patient. If billing physician or billing Medicare it is not necessary to complete this section.

Name _____
Address _____
City/State/Zip _____
Phone (H) _____ (W) _____

Fill in Patient Information



Select Method of Payment



Prepayment does not require insurance info



Fill in only if you are submitting to insurance



“Physicians Signature”
Print the following...
“Signature On File”



Type of test
“Peptide test for gluten & casein”

Diagnosis Codes
558.9
579.9
307.50



Person Responsible for Charges



Include a check for \$99.00 made out to
Great Plains Labs

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

Any questions about the test or for more instructions.
Please call Great Plains Labs at:
(913) 341-8949