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.*

Provider Information (to be completed by Provider)

Provider Name _____ 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 NOTE: *PLEASE INCLUDE THIS FORM AND COPIES OF YOUR INSURANCE CARDS (FRONT AND BACK, IF YOU HAVE THEM), IN THE BOX WITH YOUR SAMPLES WHEN YOU RETURN IT TO CDI.*

Patient Information

First Name _____ Last Name _____ Date of Birth _____

Sex:
- ☐ Male
- ☐ Female

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

Phone # _____ Email _____

Insurance Company _____ Insurance ID # _____ Group ID # _____

CDI does not currently accept any Medicaid plans

Type of Insurance:
- ☐ HMO
- ☐ PPO
- ☐ Other
- ☐ Medicare
- ☐ Medicare Advantage

Name of Insured (*if not patient*) _____ Relation _____ Date of Birth _____

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.

☐ *I elect to self-pay $175 for my test and have provided my credit card information or attached a check made payable to Commonwealth Diagnostics International, Inc.*

IMPORTANT INSURANCE & PAYMENT INFORMATION

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.
- 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 full cost of the test.

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)* _____

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