Acutis pharmacogenetics test requisition

Acutis
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CLIA ID 33D2087537 PFI 8944

Specimen identifier stickers

P 07072023
Date of birth ... / ... / ...
Patient name ...

P 07072023
Date of birth ... / ... / ...
Patient name ...

P 07072023

A Enter key information

Patient information

Last name* ... First name* ... MI ...
Date of birth* ... / ... / ... Gender ☐ M ☐ F ☐ unidentified
Address* ... City* ... State* ... Zip* ...
Phone number* ... Email ...
Ethnicity ☐ African ☐ American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Ashkenazi ☐ Other ...
Amiodarone use Nicotine use Weight ... Target INR ...

Specimen information

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

Billing information

☐ Copy of insurance card(s) attached

☐ Medicare ☐ Medicaid ☐ 3rd party insurance ☐ Self-pay
Primary insurance carrier ...
Policy I.D.# ... Group ...

*Required fields

Account number ...

B Order panel or individual tests based on medical necessity

– Must include up-to-date patient medication list, demographics, and medical records indicating medical necessity.

☐ **Pain**
COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6

☐ **Psychiatry**
COMT, CYP1A2, CYP2B6, CYP2C19, MTHFR, CYP2D6

C Diagnosis code(s)

– Please list all applicable and appropriate Diagnosis codes (ICD-10)

... ...
... ...
... ...
... ...
... ...

D Patient conditions

☐ Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
☐ Bipolar disorder, current episode depressed, mild
☐ Bipolar disorder, current episode depressed, moderate
☐ Bipolar disorder, current episode depressed, severe, without psychotic features
☐ Bipolar disorder, current episode depressed, severe, with psychotic features
☐ Bipolar disorder, current episode mixed, unspecified
☐ Bipolar disorder, current episode mixed, mild
☐ Bipolar disorder, current episode mixed, moderate
☐ Bipolar disorder, current episode mixed, severe, without psychotic features
☐ Bipolar disorder, current episode mixed, severe, with psychotic features
☐ Bipolar disorder, in partial remission, most recent episode depressed
☐ Bipolar disorder, in full remission, most recent episode depressed
☐ Bipolar disorder, in partial remission, most recent episode mixed
☐ Bipolar disorder, in full remission, most recent episode mixed
☐ Bipolar disorder, unspecified

☐ Major depressive disorder, single episode, unspecif ied
☐ Major depressive disorder, recurrent, mild
☐ Major depressive disorder, recurrent, moderate
☐ Major depressive disorder, recurrent severe without psychotic features
☐ Major depressive disorder, recurrent, severe with psychotic symptoms
☐ Major depressive disorder, recurrent, in remission, unspecified
☐ Major depressive disorder, recurrent, in partial remission
☐ Major depressive disorder, recurrent, in full remission
☐ Major depressive disorder, recurrent, unspecif ied
☐ Huntington's disease
☐ Chronic Pain Syndrome
☐ Other acute postprocedural pain
☐ Adverse effect of unspecified nonopiod analgesic, antipyretic and antirheumatic, initial encounter
☐ Long term (current) use of opiate analgesic
☐ Other long term (current) drug therapy
☐ Other ...

... ...

E Patient authorization and informed consent

I have read and signed the informed consent form attached.

Patient signature* ... Date ... / ... / ...

Authorized healthcare provider signature* ... Date ... / ... / ...

For laboratory use only
Date / time received

PGX

Acūtis

Patient authorization and irrevocable assignment of benefits

I certify that the sample was provided without tampering. I authorize Acutis Diagnostics to release the results to the ordering provider. The laboratory is authorized to bill my insurance provider(s), or any payer, whether fully or partially insured and I will irrevocably assign any payment of benefits, claims, appeal rights and interest related to the services performed by the laboratory with any payer.

I understand that in some cases, Acutis may be out-of-network or that my insurer will send payment directly to me. In the event payment is made to me, I agree to endorse the insurance check and forward it to Acutis within 30 days. My failure to forward the insurance check may result in my account being forwarded to collections or to a credit bureau. If related to no fault, I authorize assignment of benefits towards payment of services provided by Acutis. I understand that I may be responsible for charges after processing by insurance including deductible and copay/coinsurance. In the event I do not have insurance coverage, I may be fully responsible for all charges.

Provider authorization and certification of medical necessity

I acknowledge all tests are reasonable, appropriate, and medically necessary for the monitoring, care, and treatment of the patient, as documented by the patient's records. Acutis Diagnostics emphasizes the importance of testing based on medical necessity. I agree to provide documentation upon request, from the patient's medical chart, supporting medical necessity of tests ordered within 15 days of the request.

I acknowledge a listing of all applicable CPT/HCPCS codes will be made available to me upon request from the laboratory. I further acknowledge the laboratory's Annual Provider Notice is available on their website.

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Acūtis = Accūracy