



Requisition Number: \_\_\_\_\_

## Laboratory Requisition Form

### Select Profile and Select Payor

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> 40 Allergen Inhalant Profile + Total IgE | <input type="checkbox"/> Commercial Insurance/Private Pay   | <input type="checkbox"/> Self-Pay |
| <input type="checkbox"/> 28 Allergen Food Profile + Total IgE     | <input type="checkbox"/> Medicare/Tricare   |                                   |
| <input type="checkbox"/> Combined 68 Allergen Profile + Total IgE | <small>(Ordering Provider responsible to insure test meets medical necessity requirements, and is not a screening tool)</small> |                                   |

**1. Clinician Signature: (required)** \_\_\_\_\_

Clinician Name: \_\_\_\_\_ Date Collected: \_\_\_\_/\_\_\_\_/\_\_\_\_ Account #: \_\_\_\_\_

Time Collected: \_\_\_\_:\_\_\_\_ Collected by Initials: \_\_\_\_\_

### Check all diagnosis codes that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> J45.902 Asthma, Unspecified           | <input type="checkbox"/> J30.9 Allergic Rhinitis                       | <input type="checkbox"/> R05 Cough  |
| <input type="checkbox"/> J45.99 Other Asthma                   | <input type="checkbox"/> J30.8 Other Allergic Rhinitis                 | <input type="checkbox"/> R09.89 Chest Congestion                            |
| <input type="checkbox"/> J32.9 Sinusitis ( Chronic)            | <input type="checkbox"/> J30.5 Allergic Rhinitis due to Food           | <input type="checkbox"/> R51 Headache                                       |
| <input type="checkbox"/> T78.40XA Allergy, Unspecified Food    | <input type="checkbox"/> J00 Chronic Rhinitis (Acute)                  | <input type="checkbox"/> R63.8 Other Symptoms, Food Intake                  |
| <input type="checkbox"/> J45.909 Unspecified Asthma,           | <input type="checkbox"/> L27.2 Dermatitis due to Food taken internally | <input type="checkbox"/> T78.00XA Anaphylactic Reaction due to Unknown Food |
| <input type="checkbox"/> J01.9 Uncomplicated Sinusitis (Acute) | <input type="checkbox"/> H66.90 Otitis Media Unspecified               | <input type="checkbox"/> L23.9 Eczema                                       |
| <input type="checkbox"/> R09.81 Nasal Congestion               | <input type="checkbox"/> H10.45 Chronic Allergic Conjunctivitis        | <input type="checkbox"/> J31.0 Chronic Rhinitis                             |
| <input type="checkbox"/> R06.02 Shortness of Breath            | <input type="checkbox"/> Other _____                                   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Z91.018 Allergy to Other              |  |   |

Please complete below or submit a copy of your face sheet from visit with front and back of Medicare/Tricare or insurance card

**2. Patient Information: (please print)**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ DOB (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Patient or Guarantor Email Address: \_\_\_\_\_

I consent to the collection and testing of my blood for the purpose of the service noted above ("SERVICE"). I release Spiriplex, Inc. ("SPIRIPLEX"), its affiliates and any other entity and individuals associated with this SERVICE from all liability arising from the collection and testing of my blood. I acknowledge the results for the SERVICE can be affected by many factors and does not constitute medical advice or a diagnosis of any kind. I authorize SPIRIPLEX, or the billing Laboratory, to release copies of my laboratory results and data to healthcare providers and facilities for the purpose of continuing and coordinating my plan of treatment, quality assurance, regulatory or accreditation purposes. I hereby assign SPIRIPLEX, or the billing Laboratory, the medical benefits I am entitled from my health insurance plan(s) or service provider(s). SPIRIPLEX is not a provider to government health plans (State or Federal). SPIRIPLEX, or the billing Laboratory is authorized to release all information required for insurance claims and permit reproduction of this authorization for use in place of the original assignment. I consent to the release of the results and data of my SERVICE (without my name being used) in clinical and research studies and reports. Specimen to be shipped to heliosDX, to be processed by SPIRIPLEX as the reference laboratory for heliosDX.

**Patient Signature: (required)** \_\_\_\_\_ Date : \_\_\_\_/\_\_\_\_/\_\_\_\_

**Guarantor Signature (if different from Patient):** \_\_\_\_\_

**3. Billing:**

### For Medicare/Tricare or Insurance Option

- Please provide a copy of the patient's Medicare/Tricare or insurance card. (Front and Back)
- Please include **INSURED'S** DOB (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_



**Spiriplex, Inc.**  
 100 Tri-State International | Suite 100  
 Lincolnshire, IL 60069  
 T 847.393.4555  
 E info@spiriplex.com  
 CLIA #14D2063316

**heliosDX**  
 1122 Cambridge Square | Suite E  
 Alpharetta, GA 30009  
 T 423.206.2299  
 E info@heliosdx.com

CLIA #11D2102909 | Laboratory Director: K Dino Anastasiades, MD