heliosDX

Spiriplex®

Allergy Testing

Requisition Number: _____

Laboratory Requisition Form

Select Profile and Select Payor

- ☐ 40 Allergen Inhalant Profile + Total IgE
- ☐ 28 Allergen Food Profile + Total IgE
- ☐ Combined 68 Allergen Profile + Total IgE

- ☐ Commercial Insurance/Private Pay
- ☐ Medicare/Tricare
  (Ordering Provider responsible to insure test meets medical necessity requirements, and is not a screening tool)

- ☐ Self-Pay

1. Clinician Signature: (required) _____

Clinician Name: _____ Date Collected: ____/____/_____ Account #: _____

Time Collected: ____:____ Collected by Initials: _____

Check all diagnosis codes that apply:

☐ J45.902	Asthma, Unspecified	☐ J30.9	Allergic Rhinitis	☐ RO5	Cough
☐ J45.99	Other Asthma	☐ J30.8	Other Allergic Rhinitis	☐ R09.89	Chest Congestion
☐ J32.9	Sinusitis (Chronic)	☐ J30.5	Allergic Rhinitis due to Food	☐ R51	Headache
☐ T78.40XA	Allergy, Unspecified Food			☐ R63.8	Other Symptoms, Food Intake
☐ J45.909	Unspecified Asthma,	☐ J00	Chronic Rhinitis (Acute)		
☐ J01.9	Uncomplicated Sinusitis (Acute)	☐ L27.2	Dermatitis due to Food taken internally	☐ T78.00XA	Anaphylactic Reaction due to Unknown Food
☐ R09.81	Nasal Congestion	☐ H66.90	Otitis Media Unspecified	☐ L23.9	Eczema
☐ R06.02	Shortness of Breath	☐ H10.45	Chronic Allergic Conjunctivitis	☐ J31.0	Chronic Rhinitis
☐ Z91.018	Allergy to Other	☐ Other _____		☐ 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): ____/____/____

ALLERGENEX®

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