AERODIAGNOSTICS LLC™

Laboratory Requisition

561 Virginia Rd., Suite 100, Concord, MA 01742 | Tel. 617-608-3832 | Fax 617-860-6617
Website: Aerodiagnostics.com | Email: customerservice@aerodiagnostics.com

Kathleen O'Neil-Smith, MD, Medical Director

1. Clinician Information (Required- Office Use Only)

Clinician Name:		
NPI:		
Facility Name:		
Office Phone:	Office Fax:	
Address:		
City:	State:	Zip Code:

2. Breath Test Kit Requisitioned (Required- Office Use Only)

ICD-10 Codes:
1) 2) 3) 4)

☐ Small Intestinal Bacterial Overgrowth (SIBO) **with** Lactulose (*Rx*) Breath Test

☐ Small Intestinal Bacterial Overgrowth (SIBO) **without** Lactulose *(Rx)* Breath Test

Includes Lactulose Instructions. Clinician must provide a prescription for Lactulose 10g/15mL solution for patient to obtain at their local pharmacy.

(Advance Beneficiary Notice required for the above test)

☐ Small Intestinal Bacterial Overgrowth (SIBO) with Glucose Breath Test

☐ Lactose Breath Test

☐ Fructose Breath Test

☐ Sucrose Breath Test

Clinician Signature (Required)	Date:

3. Patient Information (Required- Please Print)

Patient Name:		
Date of Birth:	Gender: Male ☐ Female ☐ Other ☐	
Guarantor for Minor:		
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email:		

Definition of Medical Necessity

All claims submitted to Governmental Programs for Aerodiagnostics LLC™ breath testing must be medically necessary. Medically Necessary is defined as "a legal doctrine in the United States related to activities that may be justified as reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care" Test performed for screening purposes will not be reimbursed by Medicare. Clinicians may deem it medically necessary to order a breath test.

IT IS EASY TO COLLECT YOUR BREATH SAMPLES – JUST WATCH TWO SHORT VIDEOS! USE THE LINK BELOW FOR EACH VIDEO OR PLEASE CALL US AT 1-617-608-3832 FOR ASSISTANCE.

https://aerodiagnostics.com/#cta-2

4. Payment Preference (Required, check only one preference)

☐ **Billing Medicare, Tricare**
(Complete section 6 & 7, reverse side)
Medicare Requires an ABN
We Do Not Bill Medicaid use the "No Insurance Option"

☐ **Bill Insurance with a patient payment**
(Complete section 6 & 7, reverse side)

Partial Payment from Patient: $ 99.74

☐ **No Insurance Billing** (Complete section 7, reverse side)

Pre-payment – Please include the discounted cost of $209.74.
Payment plan – Please contact us at 1-617-608-3832.
Financial Assistance – Please contact us at 1-617-608-3832.

5. Instructions on Payment

Aerodiagnostics is a Out of Network Provider

1. If choosing to have your COMMERCIAL INSURANCE billed, please follow the below steps:
   a. Submit the required Partial Payment by completing the insurance and payment section.
   b. We will bill a claim to your carrier. If there are additional monies due, you will receive a billing statement. A minimum due of $209.74 total cost.
   c. Act promptly and pay by the date indicated, or discount options may expire.

   Please note: We do not participate with Medicaid
2. If choosing NO INSURANCE, please complete the payment section for FULL PAYMENT of the discounted cost $209.74.
3. If you require a Payment Plan or Financial Assistance, please contact us at 1-617-608-3832.

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6. Insurance Information (Please include a copy front & back)

Name of Subscriber:		Subscriber DOB:
Patient's Relationship to Subscriber: Self ☐ Spouse ☐ Dependent ☐ Other ☐		
Insurance Carrier:		
Claim Address:		
City:	State:	Zip Code:
Insurance ID #:		Group #:

7. Payment Information (Please Print)

☐ Check # _____ Check Amount $ _____		
Credit Card #:		
Exp. Date:	CVV:	Billing Zip Code:
Printed Name:		
Cardholder Signature:		

Advance Beneficiary Notice of Non-coverage: If all insurance including Medicare does not pay for this test, beneficiary will receive a billing statement with a minimum due of $209.74. Please be aware Medicare does not pay for all tests, even some tests that you or your health care provider have good reason to believe you need. We expect Medicare will not pay for this test.

- I understand the tests on the front of this form may be deemed not medically necessary, experimental, or investigational by my health plan and I authorize the services to be performed and to be financially responsible for a minimum payment of $209.74.
- I acknowledge that Aerodiagnostics LLC™ does not contract with my insurance company and therefore will be out of network.
- I agree that if my insurance company denies the claim(s), does not pay the claim(s) in full, or if I have not met my deductible, I will be responsible for the Patient Responsibility to Aerodiagnostics LLC™
- I authorize Aerodiagnostics, LLC™ to file claim(s) with my insurance company on my behalf.
- I authorize the payment of all medical benefits to be paid directly to Aerodiagnostics LLC™ and authorize the release of any medical information required to my insurance company(s) for the payment of services rendered by Aerodiagnostics LLC™ to process/pay claims.
- I authorize Aerodiagnostics LLC™ to function as my representative in any claim appeal process. I permit a copy of the requisition to be used in place of the original.
- I acknowledge that I may receive an Explanation of Benefits (EOB) letter from my insurance company following the filing of the claim(s) by Aerodiagnostics LLC™ for services rendered.
- I understand that my insurance company may send payment for this test directly to me. I agree that if this happens, I will forward that payment directly to Aerodiagnostics LLC™. I may also send a personal check, money order, bank check, or pay by credit card for service rendered to Aerodiagnostics LLC for the full amount sent to me by my insurance company.
- Aerodiagnostics LLC™ is available at 1-617-608-3832 and/or customerservice@aerodiagnostics.com to answer any payment, insurance, and/or Explanation of Benefit (EOB) questions.
- I authorize Aerodiagnostics LLC™ to charge my credit card for the $209.74 which includes the partial payment of $99.74.
- I authorize the release of all information related to this order to the listed clinician(s) and their designee(s) to facilitate test(s) processing and billing for services rendered.
- I understand that I am responsible for payment of $59.95 to Aerodiagnostics LLC™ for this breath collection kit should I not return the collection kit completed within 60 days.
- Aerodiagnostics LLC™ cannot discuss results directly with a patient.
- I understand that Massachusetts Law prohibits distribution of test results directly to patients without the ordering clinician's authorization.
- I acknowledge that I may receive correspondence from Aerodiagnostics LLC™ in the form of email, text message, or by phone.
- Under the General Data Protection Regulation (GDPR) issued by the European Commission, Aerodiagnostics LLC™ is a third-party processor of that Customer Personal Data; the above signed Clinician is a controller and/or processor, as applicable, of that Customer Personal Data under the European Data Protection Legislation; and each party will comply with the obligations applicable to it under GDPR Legislation with respect to the processing of that Customer Personal Data. Aerodiagnostics LLC™ is permitted to process Customer Personal Data only in accordance with applicable law: (a) to provide the services as designated above and related technical support; (b) as further specified via Customer's use of the Services; (c) as documented in the form of the applicable Agreement, including this Data Processing Amendment; and (d) as further documented in any other written instructions given by Customer and acknowledged by Aerodiagnostics LLC™ as constituting instructions for purposes of this Data Processing Amendment. The customer should contact the clinician of record for details regarding the scope of processing agreement and subject's personal data rights.

I have read the Signature Guidelines and I understand my responsibilities as described within them.

X	Date: