# AERODIAGNOSTICS LLC™

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## Laboratory Requisition

Kathleen O'Neil-Smith, M.D. Medical Director

**Clinician Information**

Clinician Name: _____ NPI#: _____

Office Phone: _____ Office Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

ICD-10 Code(s): (1) (2) (3) (4)

**Clinician Signature:** Date:

**Breath Test Kit Requisitioned**

- ☐ Small Intestinal Bacterial Overgrowth- SIBO, Lactulose Breath-Test
- ☐ Small Intestinal Bacterial Overgrowth- SIBO, Glucose Breath-Test
- ☐ Lactose Breath-Test
- ☐ Fructose Breath-Test
- ☐ Sucrose Breath-Test

**Patient Information**

**Date of Test:** _____ **Gender:** (optional) ☐ **Female** ☐ **Male** ☐ **Other**

Patient Name (Print; First, Middle, Last): _____

Address: _____

City: _____ State: _____ ZIP: _____ Date of Birth: _____

Home Phone: _____ Work: _____ Cell: _____

E-Mail:

**Credit Card Payment Information**

**Credit Card** (Check one): **Visa** **MasterCard** **AMEX** **Discover** **Other** **Billing Zip Code:** _____

**Credit Card Number:** _____ **Expiration:** _____ **Security Code:** _____

**Name as it appears on the Credit Card:**

**Patient Primary Insurance & Subscriber Information**

*(Please attach a copy of the patient's insurance card – front & back )*

**Insurance Carrier:** _____ **Subscriber's Date of Birth:** / /

**Insurance ID#:** _____ **Group ID#:** _____

**Address for Claims:** _____

**City:** _____ **State:** _____ **Zip:** _____ -

**Name of Insured/Subscriber** (*If different from patient*): _____

**Relationship to Patient:** _____ **Address:** _____

**City:** **State:** **Zip:** -

**Signature of Patient or Authorized Responsible Party**

I acknowledge that Aerodiagnostics LLC™ may or may not contract with insurance companies and will file claims with my insurance company on my behalf **(NO Medicare/Medicaid/Tricare)**.

I agree that if my insurance company denies the claim(s), does not pay the claim in full, or if I have not met my deductible, I will be responsible for payment to Aerodiagnostics LLC™ as directed by my insurance company and as outlined within my specific insurance policy. If I do not supply insurance information, I will be responsible for a minimum payment of $199.74.

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 to Aerodiagnostics LLC™ for the **full amount sent to me by my insurance company.**

Aerodiagnostics LLC™ offers payment plans for services rendered. Contact customerservice@aerodiagnostics.com for more details.

Aerodiagnostics LLC™ is available at 1-617-608-3832 to answer any payment or insurance questions. Aerodiagnostics LLC™ is also available to answer questions regarding explanation of benefit letters.

I agree to return this test kit to Aerodiagnostics LLC™, even if I have not taken the test. I will not utilize the prepaid postage inside the kit to return an unused kit.

I understand that I am responsible for payment of $59.95 to Aerodiagnostics LLC™ for this test kit should I not return the test kit within 60 days.

I authorize Aerodiagnostics LLC™ to release all medical information required to my insurance company(s) for the payment of services rendered by Aerodiagnostics LLC™.

I authorize Aerodiagnostics LLC™ to charge my credit card for the amount designated by my insurance company.

I authorize the release of all information related to this order to the listed physician(s), clinician(s) and their designee(s) to facilitate test(s) processing and billing for services rendered.

**X** Date:

*(Signature Required or Test Cannot Be Processed)*