AERODIAGNOSTICS LLC™

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Website: aerodiagnostics.com | Email: customerservice@aerodiagnostics.com

Laboratory Requisition

Lisa M. Cohen, MD, Laboratory Director

Welcome to Aerodiagnostics!

1. You received this Aerodiagnostics breath test collection kit because either you or your clinician ordered it.
2. Call the Aerodiagnostics Laboratory directly at **1-617-608-3832** with any questions regarding this test (eg. How to use the kit, cost, test preparation, this form).
3. See the reverse side of this form for a link to the Aerodiagnostics website to view our "How to take an Aerodiagnostics breath test" three (3) minute video.
4. Complete this form and return it with your breath specimens. This form will be attached to the original order we have on file.
5. Utilize this form to make any changes to your personal information.
6. Please be sure to sign and date this form in the designated space at the bottom to authorize Aerodiagnostics to perform this test.

Your Physician/Clinician's Name:

Patient Information

Date of Test: ______________ **Gender:** (Circle One) **Female Male** ______ **SSN:** (Optional) ______________

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™ may contract with insurance companies and will file claims to my insurance company on my behalf.
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 of $199.74 to Aerodiagnostics LLC™.
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, using the pre-paid/self-addressed shipping label included in the test 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 also
I authorize Aerodiagnostics LLC™ to charge my credit card for the amount designated.
I authorize the release of all information related to this order to the listed physician(s) and their designee(s) to facilitate test(s) processing and billing for services rendered.

X Date:

(Signature Required or Test Cannot Be Processed)