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 with original Medicare only)

☐ 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:		

4. Payment Preference (Required- Office Use Only, check only one preference)

☐ **Billing Medicare, Tricare**
(Complete section 6 & 7, reverse side)
Original Medicare Requires an ABN
All Medicaid Plans use the "No Insurance Option"

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

Initial Payment from Patient: $ 99.74

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

Pre-payment – Please include full cash price.
Payment plan – Please contact us at 1-617-608-3832.
Financial Assistance – Please contact us at 1-617-608-3832.

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 test or procedure that is reasonable and necessary for diagnosis treatment of illness." 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

5. Instructions on Payment

Please note: We do not participate with Medicaid

1. If choosing to have your COMMERCIAL INSURANCE or MEDICARE ADVANTAGE billed, please follow the below steps:
   a. Submit the required Initial 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.
   c. Act promptly and pay by the date indicated, or discount options may expire.
2. If choosing NO INSURANCE, please complete the payment section for FULL PAYMENT of $209.74.
3. If you require a Payment Plan or Financial Assistance, please contact us at 1-617-608-3832.

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

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

Advance Beneficiary Notice of Non-coverage: If Medicare does not pay for this test, beneficiary may be responsible for payment. 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 may 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 authorize the services to be performed and to be financially responsible for the company's fees.
- I acknowledge that Aerodiagnostics LLC™ may not contract with my insurance company and therefore may 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 may be responsible for the Patient Responsibility amount as directed by my insurance carrier based on my policy to Aerodiagnostics LLC™.
- I authorize that Aerodiagnostics, LLC™ 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 act as my representative in any claim appeal process. I permit a copy of this 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 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 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.
- 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 clinician(s) and their designee(s) to facilitate test(s) processing and billing for services rendered.
- 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 Guidelines and I understand my responsibilities as described within them.

X	Date: