AERODIAGNOSTICS LLC™

Laboratory Requisition

Lisa M. Cohen, M.D. Laboratory Director

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

Physician Information

Physician Name: _____ NPI#: _____

Office Phone: _____ Office Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

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

Physician Signature: Date:

Breath Test Kit Requisitioned

- ☐ Small Intestinal Bacterial Overgrowth- SIBO, Lactulose Breath-Test
- ☐ Small Intestinal Bacterial Overgrowth- SIBO, Glucose Breath-Test
- ☐ Fructose Breath-Test
- ☐ Lactose Breath-Test
- ☐ Sucrose Breath-Test
- ☐ Pregnancy Test Clarity Diagnostics Human Chorionic Gonadotropin

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 LLC™ 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 may be responsible for the Patient Responsibility amount as directed by my policy 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 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 breath collection kit to Aerodiagnostics LLC™, even if I have not taken the test.

I understand that I am responsible for payment of $59.95 to Aerodiagnostics LLC™ for this breath collectiont 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.

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)