

ORDERING PHYSICIAN

By signing below, I hereby certify that I am licensed to order clinical laboratory tests:

PHYSICIAN PRINTED NAME _____ PHYSICIAN SIGNATURE _____ DATE _____

LABORATORY USE

OK: _____ D: _____ STP DBS
BT ST VOL: _____
REJ: _____ D: _____ U US
NEWDR
PROC AD ML TEST DOB D/C
SMPL WET UNL QNS EXP KEXP
INSU ICD9 SIGN BOX
BILL PCC

PATIENT

PATIENT LAST NAME PLEASE PRINT CLEARLY FIRST NAME PLEASE PRINT CLEARLY M.I. SEX DATE OF BIRTH MM DD YYYY
ADDRESS
CITY STATE ZIP DAY PHONE EVENING PHONE

ICD-9 NUMERIC CODES highest specificity
This information is required for insurance billing

PAYMENT

insurance billing
 check enclosed
 credit card
 bill physician *Physician assumes payment responsibility.*

CHECK NUMBER CREDIT CARD NUMBER CARD EXP. DATE MM YY
AMOUNT (USD) CARDHOLDER NAME PLEASE PRINT CLEARLY CARDHOLDER SIGNATURE _____ DATE _____

Regardless of any secondary insurance, our service is NOT available to Medicare or Medicaid patients.

SPECIMEN

DATE COLLECTED MM DD YY STORAGE PRIOR TO SHIPMENT
TIME COLLECTED HH : MM AM PM frozen
DATE SENT MM DD YY refrigerated
 room temp.

INSURANCE

INSURANCE PROVIDER NAME PHONE
ADDRESS CITY STATE ZIP
SUBSCRIBER LAST NAME PLEASE PRINT CLEARLY FIRST NAME PLEASE PRINT CLEARLY M.I. DATE OF BIRTH MM DD YYYY
RELATIONSHIP TO PATIENT self spouse parent other: _____
POLICY NUMBER
MEMBER ID
GROUP NUMBER

INSURANCE AGREEMENT: By signing below, I request that payment of all medical benefits be paid directly to US BioTek. I understand that I will be held responsible for any portion of the claim not covered by insurance and any finance charges incurred (18% per annum). I authorize any holder of my personal medical information to release such information necessary for this claim. I further agree that a copy of this original requisition form can be used in place of the original.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

By choosing the **insurance billing** option, you are requesting that we bill your insurance provider for the test service as requested by your physician.

For **insurance billing**, US BioTek requires the following:

- check **insurance billing** box
- complete insurance information
- complete ICD-9 codes
- sign **INSURANCE AGREEMENT**
- copy of insurance card (front and back)

TEST MENU

IMMUNOLOGY - IgE+IgG

sample volume requirement: serum

96F	96 General Food	5 mL
96V	96 Vegetarian Food	7 mL
16V	16 Vegetarian Food	2 mL
48H	24 Herb + 24 Spice	2 mL
64I	64 Inhalant IgE-only	3 mL

IMMUNOLOGY - IgA

sample volume requirement: DBS* serum

96FA	96 General Food	1	1 mL
96VA	96 Vegetarian Food	2	1 mL
16VA	16 Vegetarian Food	1	1 mL
48HA	24 Herb + 24 Spice	1	1 mL
16IA	16 Inhalant	1	1 mL

HORMONE - URINE SAMPLE

UHP Urinary Steroid Hormone Profile

The following information is **required** for Urinary Hormone Profile testing. TOTAL URINE VOLUME _____ mL

MEDICATION(S), IF ANY _____

FEMALES ONLY PRE-menopause POST-menopause LATEST MENSTRUAL CYCLE DATE MM DD (date of the beginning of last menstrual flow)

IMMUNOLOGY - IgG

sample volume requirement: DBS* serum

96FG	96 General Food	1	1 mL
96VG	96 Vegetarian Food	2	1 mL
16VG	16 Vegetarian Food	1	1 mL
48HG	24 Herb + 24 Spice	1	1 mL
16IG	16 Inhalant	1	1 mL

See reverse side for additional information

IMMUNOLOGY - MISC

sample volume requirement: DBS* serum

CAN	Candida Antibody and Antigen Panel	1	2 mL
CEL	Celiac Antibody Panel	2	2 mL
PAP	Painkiller Antibody Panel	2	1 mL

CHEMISTRY - URINE SAMPLE

EPP Environmental Pollutants Profile

UMP Urinary Metabolic Profile

96 REGION-SPECIFIC FOOD Please choose the desired 96 Food panel region, unless ordering the 96 General Food panel.

96A 96 Asian Food 96J 96 Japanese Food 96M 96 Mexican Food

Missing or incomplete information may delay test results. Insufficient specimen may result in the inability to complete testing for all panels ordered.

There is a \$15 fee for submittal of an unacceptable specimen.

* DBS cards must be complete, with all 5 spots (per card) fully saturated with whole blood.