



Date Received Stamp

*PRACTICE INFORMATION

PLACE BARCODE HERE

Practice Name:

*Address:

*Physician:

*NPI:

*Phone No:

And on each tube lengthwise

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PLEASE ATTACH DETAILED MEDICAL RECORDS, INSURANCE CARD FRONT/BACK, AND CLINICAL INFORMATION TO THE REQUISITION FORM.

TOXICOLOGY, URINARY TRACT INFECTION & URINALYSIS TEST PANEL REQUISITION FORM

PATIENT INFORMATION*

SPECIMEN COLLECTION INFORMATION

*First Name:

Middle Name:

*Collection Date: MM / DD / YYYY

*Last Name:

*Gender: Male Female Others

*Collected By:

*Address:

*City:

*State:

*Time: Temperature:

*Zip Code:

*Date of Birth: MM / DD / YYYY

*Mobile No:

Urine

Bill To: Insurance Medicare Patient Medicaid Client Bill

*INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder Self Spouse Child
Name and DOB of Policy Holder (If not self)

Name:

Date of Birth: MM / DD / YYYY

Insurance Company:

Policy#

Group:

*ICD-10
Diagnosis Code(s):

*Urinary Tract Infection Disease Panel

Urinalysis Test Panel

Gram Negative - 13

- 1. Acinetobacter baumannii
2. Enterobacter aerogenes
3. Enterobacter cloacae
4. Escherichia coli
5. Klebsiella oxytoca
6. Klebsiella pneumoniae
7. Providencia stuartii
8. Pseudomonas aeruginosa
9. Citrobacter koseri
10. Serratia marcescens
11. Citrobacter amalonaticus
12. Pantoea agglomerans

Gram Positive - 14

- 1. Enterococcus faecalis
2. Enterococcus faecium
3. Staphylococcus aureus
4. Staphylococcus saprophyticus
5. Streptococcus agalactiae
6. Staphylococcus lugdunensis
7. Staphylococcus haemolyticus
8. Streptococcus oralis
9. Aerococcus urinae
10. Corynebacterium riegelii
11. Corynebacterium urealyticum

STREPTOCOCCUS SPECIES

- 12. Streptococcus pasteuranus
13. Streptococcus pyogenes
14. Staphylococcus epidermidis

STD - 5

- 1. Chlamydia trachomatis
2. Trichomonas vaginalis
3. Treponema pallidum
4. Mycoplasma genitalium
5. Neisseria gonorrhoeae

Fungal - 3

- 1. Candida Albicans
2. Candida Glabrata
3. Candida parapsilosis

Others - 3

- 1. Mycobacterium tuberculosis
2. Mycoplasma hominis
3. Ureaplasma urealyticum

Antibiotic Resistance - 15

- 1. ACT/MIR 6. TEM 11. gyrA
2. vanA 7. ermB 12. mecA
3. vanB 8. ermC 13. tetM
4. vanC 9. ermA 14. sul1
5. KPC 10. qnrS 15. dfrA

Urinalysis

- 1. Leukocytes
2. Nitrite
3. Urobilinogen
4. Protein
5. pH
6. Blood
7. Specific Gravity
8. Ketone (Ascorbic Acid)
9. Bilirubin
10. Glucose

Toxicology Order

Confirmation Test Request

- Screen and confirm Boxes Checked Below
Screen and Confirm All Negative and Positive Results
Screen Only
Confirm All Negative and Positive Results
Confirm Only Boxes Checked Below

All Samples received by the lab that undergo screening will also undergo validity testing (Creatinine, pH, Oxidants) to confirm that sample has not been adulterated or Diluted

Amphetamines

- 1. Amphetamines
2. Methamphetamine

Anti Depressants (TCAs)

- 1. Amitriptyline
2. Doxepin
3. Imipramine
4. Nortriptyline
5. Norquetiapine
6. Norstraline
7. Quetiapine
8. Sertraline

Barbiturates

- 1. Butalbital
2. Phenobarbital

Buprenorphine

- 1. Buprenorphine
2. Norbuprenorphine

Benzodiazepine

- 1. 7-Aminoclonazepam
2. alpha-Hydroxylprazolam
3. Alprazolam
4. Clonazepam
5. Diazepam
6. Flunitrazepam
7. Flurazepam
8. Lorazepam
9. Nordiazepam
10. Oxazepam
11. Temazepam

Fentanyl

- 1. Fentanyl
2. Norfentanyl

Hypnotics

- 1. Zolpidem
2. Zolpidem Phenyl 4-COOH

Methadone

- 1. EDDP
2. Methadone

Methylenedioxy-amphetamines

- 1. MDA
2. MDMA

Opiates

- 1. Codeine
2. Morphine

Opioids and Opiate Analogs

- 1. Hydrocodone
2. Hydromorphone
3. Meperidine
4. Normeperidine
5. Dihydrocodeine
6. Levorphanol/Dextrorphan
7. Noroxycodone
8. Norhydrocodone

Skeletal Muscle Relaxants

- 1. Carisoprodol
2. Cyclobenzaprine
3. Meprobamate

Oxycodone

- 1. Oxycodone
2. Oxymorphone

Tramadol

- 1. O-Desmethyltramadol
2. Tramadol

Stimulants

- 1. MDPV
2. Methylphenidate
3. Phentermine

Cotinine

- 1. EDDP

Dextromethorphan

- 1. MDPV

PCP

- 1. MDPV

Pregabalin

- 1. MDPV

Propoxyphene

- 1. MDPV

Tapentadol

- 1. MDPV

O-Naloxone

- 1. MDPV

THC-COOH

- 1. MDPV

Screening Tests

- 1. Amphetamine
2. Barbiturates
3. Benzodiazepines
4. Buprenorphine
5. Cannabinoids
6. Ethyl Alcohol
7. Methadone
8. Opiates
9. Oxycodone
10. TCA
11. pH
12. Urine Creatinine
13. Fentanyl
14. Cocaine

*Patient Acknowledgment

Authorization to Release Information:

I hereby authorize my treating provider and "MicroGen Health" to: (1) release any information necessary to insurance carriers and providers regarding my illness, treatments and results; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Assignment of Benefits:

I hereby assign all medical benefits, to include major medical and diagnostic benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to MicroGen Health for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient Attestation:

I certify that I have voluntarily provided a fresh and unadulterated specimen for diagnostic laboratory testing. The information provided on this form and on the specimen collection device is accurate. I acknowledge that MicroGen Health may be an out of network provider with my insurer. I am also aware that in some cases my insurer may send the payment directly to me and if that happens I agree to endorse the check to MicroGen Health within 15 days. I understand that MicroGen Health may use my specimen and any testing performed on that specimen for research development and potential publication purposes as long as the information has been properly de-identified pursuant to applicable law.

*Patient Signature *Date: MM / DD / YYYY

By Checking this box, the ordering provider certifies that the patient cannot physically Sign the Release and Consent

*Parent/Guardian signature *Name: *Date: MM / DD / YYYY

*Authorized Healthcare Provider Acknowledgment

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity

Statement of Medical Necessity

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

*Ordering Physician Signature *Name: *Date: MM / DD / YYYY

Toxicology Order Medical Necessity

*Patient Name:	*Patient DOB: MM / DD / YYYY	Date of Service: MM / DD / YYYY
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I,am writing an order for a Toxicology test for this patient for the following reason(S) marked. This order will remain in effect for the next twelve (12) months and/or while under my care.
(Provider Name)

- New Patient to establish a baseline.
- Patient Who is on chronic controlled medication(s).
- Patient with a history of substance abuse.
- Patient requesting refill on any controlled medication.
- Patient undergoing surgery-to ensure no abuse or elicits or controlled medications that may have adverse effects on anesthesia and surgery.
- The patient is suspected of abusing and/or diverting with current medication(s).
- Other diagnostic or medical reasons not noted above.

Please explain:

I certify that the testing referenced above is medically necessary. I intend to utilize the test results to inform my treatment decision as indicated in the application section above.

Urinary Tract Infection Medical Necessity

Dear Provider,

Since indicated that you wish to order a Urinary Tract Infection Panel OR you have requested a urinalysis to reflex to the UTI Panel if anything is positive, please complete the Medical Necessity Letter below. Please do not use a stamped signature on this form.

Thank you.
MicroGen Health

*Patient Name:	Date of Service: MM / DD / YYYY	*Patient DOB: MM / DD / YYYY
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ICD Codes:

Dear Claims Specialist:

Please consider this letter of Medical Necessity a formal request for full coverage of the Urinary Tract Infection Panel testing services that I intend to prescribe for your subscriber (Patient Name Listed Above). The results will assist me in making patient-specific clinical decisions regarding the medical management of your subscriber.

To provide the safest, most effective, and most affordable medical care possible, the requested molecular testing is medically necessary for my patient for the following reason(s):

- Patient presents with urinary tract discomfort or UTI common symptoms
- Patient has a history of UTIs, and I would like to determine whether it is a bacterial or fungal infection
- I have ordered a urinalysis to determine if symptoms are from a UTI, if anything is positive, I would like to reflex to a UTI panel

Others:

Because of this, the Urinary Tract Infection Panel will help me to determine what bacterial or fungal illnesses to treat.

Best Regards,

Name of Practice:

*Name of Physician:	Physician NPI:
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Ordering Physician Signature:	Date: MM / DD / YYYY
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(Please do not use a stamped signature)

*Clinician prescribing requirements vary by state