Date Received Stamp

MicroGen HEALTH

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*PRACTICE INFORMATION		PLACE BARCODE HERE
Practice Name:		And on each tube lengthwise
*Address:		
*Physician:		
*NPI:	*Phone No:	

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*

*First Name: | Middle Name:

*Last Name: | *Gender: ○ Male ○ Female ○ Others

*Address: | *City: | *State:

*Zip Code: | *Date of Birth: MM / DD / YYYY | *Mobile No:

Bill To: ☐ Insurance ☐ Medicare ☐ Patient ☐ Medicaid ☐ Client Bill

SPECIMEN COLLECTION INFORMATION

*Collection Date: MM / DD / YYYY

*Collected By:

*Time: Temperature:

☐ Urinary Tract Infection Disease Panel
☐ Urine Toxicology Order
☐ Urinalysis

☐ *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

☐ 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
13. Proteus mirabilis

☐ Gram Positive - 14
1. Enterococcus faecalis
2. Enterococcus faecium
3. Staphylococcus aureus
4. Staphylococcus saprophyticus
5. Streptococcus agalactiae
6. Staphylococcus lugdunenesis
7. Staphylococcus haemolyticus
8. Streptococcus oralis
9. Aerococcus urinae
10. Corynebacterium riegelii
11. Corynebacterium urealyticum
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

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

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

Urinalysis Test Panel

☐ 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

☐ 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

Medication Information

☐ Medication list attached
☐ Patient Report "No Medication

Confirmation Test Request

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. Norquetaipine
6. Norsetraline
7. Quetiapine
8. Sertraline

☐ Barbiturates
1. Butalbital
2. Phenobarbital

☐ Buprenorphine
1. Buprenorphine
2. Norbuprenorphine

☐ Benzodiazepine
1. 7-Aminoclonazepam
2. alpha-Hydroxyalprazolam
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 /Dextrophane
7. Noroxycodone

☐ 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
☐ Dextromethorphan
☐ PCP
☐ Pregabalin
☐ Propoxyphene
☐ Tapentadol
☐ O-Naloxone
☐ THC-COOH
☐ Benzoylecgonine
☐ Gabapentin
☐ 6-MAM
☐ Naltrexone
☐ EtG
☐ EtS

☐ 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, URINARY TRACT INFECTION & URINALYSIS TEST PANEL REQUISITION FORM

Toxicology Order Medical Necessity

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

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

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 Clinician:

Clinician NPI:

Ordering Clinician Signature:

Date: MM / DD / YYYY

(Please do not use a stamped signature)

*Clinician prescribing requirements vary by state