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.

NAIL INFECTION PANEL REQUISITION FORM

PATIENT INFORMATION*

*First Name:	*Last Name:	
Middle 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 & Time:

*Collector's Name:

*Specimen Source

☐ Nail & Tissues ☐ Nail

☐ *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:	DOB: MM / DD / YYYY
Insurance Company:	Policy#	Group:

Nail Infection Panels

☐ **Bacterial**

1. Pseudomonas Aeruginosa
2. Streptococcus Agalactiae (Group B Strep)
3. Streptococcus Pyogenes (Group A Strep)
4. Staphylococcus Aureus

☐ **Fungal**

1. Acremonium Strictum
2. Alternaria
3. Aspergillus Flavus
4. Aspergillus Fumigatus
5. Aspergillus Niger
6. Aspergillus Terreus
7. Aspergillus Versicolor
8. Blastomyces Dermatitidis, Blastomyces Gilchristii
9. Candida Albicans
10. Candida Glabrata
11. Candida Krusei
12. Candida Lusitaniae
13. Candida Parapsilosis
14. Candida Tropicalis
15. Curvularia Lunata
16. Epidermophyton Floccosum
17. Fusarium Oxysporum
18. Fusarium Solani
19. Malassezia Furfur, Restricta, Sympodialis, Globosa
20. Microsporum Sp.
21. Neofusicoccum Mangiferae
22. Neoscytalidium Dimidiatum
23. Scopulariopsis Brevicaulis
24. Trichophyton Spp
25. Trichosporon Asahii
26. Trichosporon Mucoides

☐ **Antibiotic-Resistant Genes**

1. Methicillin (mecA)
2. VANA, VANB, VANC

ICD-10 Codes

_____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____

*Patient Acknowledgment

The specimen identified on this form is my own. I have not adulterated it in any way. I am voluntarily submitting this specimen for analysis by my physician and/or MicroGen Health. I authorize MicroGen Health to release the results of this test to the ordering provider. I authorize my insurance benefits to be paid directly to MicroGen Health for services I received. MicroGen Health is authorized to bill my insurance provider and receive payment of benefits for the testing my provider orders. Should I receive payment for services provided by MicroGen Health I will remit payment in full to MicroGen Health I understand failure to do so may subject my account to collection activity and/or other legal action deemed necessary to reconcile my account. I further authorize MicroGen Health and my provider to release to my insurance company any medical information necessary to process this claim. My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any other time.

I acknowledge that MicroGen Health may be an out-of-network facility/provider with my insurance provider. I am also aware that in some circumstances my insurance provider may send the payment directly to me. I agree to endorse the insurance check and forward it to MicroGen Health, within 15 days of receipt as payment towards the lab services provided by MicroGen Health. I acknowledge that I am responsible for any amounts not covered by my insurance including any deductibles and co-payments / co-insurance. I understand that MicroGen Health may use my specimen and any testing performed on that specimen for research and development so long as the information has been de-identified pursuant to law.

☐ I would like to opt out of giving my sample for MicroGen Health research and development purpose.

*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