ACUPATH LABORATORIES, INC
www.acupath.com

GASTROINTESTINAL PATHOGEN REQUISITION FORM

SGIPATH-01

"FOR THE ABSOLUTE HIGHEST STANDARD IN GASTROINTESTINAL PATHOGEN PCR" © 2024

ANY OMISSION MAY RESULT IN DELAY OF REPORT

CLIA#: 33D0912[illegible]0

PATIENT INFORMATION - ALL REQUIRED

☐ AM ☐ PM

Collection Date:_____/_____/ 20_____ **Collection Time:**_____

DOB: (MM/DD/YYYY): _____/_____/_____ **SSN #:** _____-_____-_____

Gender: ☐ Male ☐ Female ☐ Other:_____

Last Name:_____ First Name:_____

Cell #:_____ Email:_____

Street Address:_____ Apt #:_____

City:_____ State: _____ Zip:_____

ORDERING PHYSICIAN INFO. (Required)

ACCT#: ____

PRACTICE NAME
ADDRESS
CITY, ST ZIP
TEL - FAX

PHYSICIAN NAME

INSURANCE INFORMATION (Required)

Policyholder Name:_____ Group #:_____

Insurance Name:_____ Policy #:_____

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD(S) OR ANY SECONDARY INSURANCE.

☐ Bill Medicare
☐ Bill Medicaid
☐ Bill Insurance
☐ Bill Patient

GASTROINTESTINAL PATHOGEN PANEL TESTING

☐ **STANDARD GI PATHOGEN (BioFire®) PANEL**

BACTERIA:
- Campylobacter (C. jejuni/C. coli/C. upsaliensis)
- Clostridoides (Clostridium) difficile (toxin A/B)
- E. coli O157
- Enteroaggregative E. coli (EAEC)
- Enteropathogenic E. coli (EPEC)
- Enterotoxigenic E. coli (ETEC) lt/st
- Plesiomonas shigelloides
- Salmonella
- Shiga-like toxin-producing E. coli (STEC) stx1/stx2
- Shigella/Enteroinvasive E. coli (EIEC)
- Vibrio (V. parahaemolyticus/V. vulnificus/V. cholerae)
- Vibrio cholerae
- Yersinia enterocolitica

VIRUSES:
- Adenovirus F40/41
- Astrovirus
- Norovirus GI/GII
- Rotavirus A
- Sapovirus (I, II, IV, and V)

PARASITES:
- Cryptosporidium
- Cyclospora cayetanensis
- Entamoeba histolytica
- Giardia lamblia

ICD-10-CM CODES that support medical necessity (Required)

These are the diagnosis codes corresponding to coverage of CPT Group 2 codes - Highly Multiplexed GPPs.
One of these diagnosis codes must be on the claim in addition to the sign or symptom for which there is suspicion of gastrointestinal illness (Group 1 code).

PICK ONE OF THE CODES IN THIS GROUP - PRIMARY DIAGNOSES

- ☐ **A04.8** Other specified bacterial intestinal infections
- ☐ **A08.19** Acute gastroenteropathy due to other small round viruses
- ☐ **B20** Human immunodeficiency virus [HIV] disease
- ☐ **D61.0** Other constitutional aplastic anemia
- ☐ **D61.818** Other pancytopenia
- ☐ **D70.9** Neutropenia, unspecified
- ☐ **D83.9** Common variable immunodeficiency, unspecified
- ☐ **D84.9** Immunodeficiency, unspecified
- ☐ **E08.43** Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
- ☐ **K50.919** Crohn's disease, unspecified, with unspecified complications
- ☐ **K51.419** Inflammatory polyps of colon with unspecified complications
- ☐ **K51.919** Ulcerative colitis, unspecified with unspecified complications
- ☐ **K56.7** Ileus, unspecified
- ☐ **R10.0** Acute abdomen
- ☐ **R10.13** Epigastric paindisease
- ☐ **R10.816** Epigastric abdominal tenderness
- ☐ **R10.817** Generalized abdominal tenderness
- ☐ **R10.819** Abdominal tenderness, unspecified site
- ☐ **Other:**_____

THEN PICK ONE OF THE CODES IN THIS GROUP
SECONDARY DIAGNOSES

- ☐ **A09** Infectious gastroenteritis and colitis, unspecified
- ☐ **R19.7** Diarrhea, unspecified

De-identified patient data may be used for R&D purposes.

Ordering Physician's Signature *(Required)*:_____

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc. I hereby give my consent to PCR based testing. I also acknowledge that my physician has explained the reason for the test and about possible medical decisions that will be made based on the findings from the test. I understand that the lab test may be sent to a non-participating laboratory for quicker turn around and quality of the service and I am made aware of possible higher out of pocket expenses. I hereby authorize the lab and its personnel to appeal on my behalf with the insurance for any denial of payment. I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature *(Required)*:_____ Authorized Signature:_____