RU_ALLERGIC?

TEST REQUISITION FORM

1 PATIENT DEMOGRAPHIC INFORMATION

(REQUIRED - THIS **PAGE** AND **COPY OF VALID DRIVER'S LICENSE**):

Last Name/First Name/M.I.

/ /

Address/City/State/Zip

/ / /

Phone Number (____-____-_____) Email: _____

☐MALE ☐FEMALE RACE:_____ DATE OF BIRTH:____/____/____

PAYMENT INFORMATION

(**REQUIRED** - photocopy of **both sides/INSURANCE CARD(s); both sides/VALID CREDIT CARD**):

☐**INSURANCE** (PROVIDE CARD): ☐**CASH (SELF PAY)** ☐**CLIENT PAY** ☐**WORKER'S COMP** ☐**AUTO**

SPECIMEN INFORMATION

TIME_____ (24-hour time) ☐**Fasting** ☐**Non-fasting**

☐**Serum** ☐**Dry Blood Spot Card (DBS)** **Number of Cards Include**_____

Phlebotomist Name:_____

2 PROVIDER INFORMATION

(NCLUDE MEDICAL **NECESSITY ICD-10 CODES/NOTES** BELOW):

Practice or Clinic Name

Address/City/State/Zip

/ / /

Ordering Provider/NPI

/ Phone Number (____-____-_____)

DIAGNOSIS CODES REQUIRED.

PLEASE PROVIDE ALL RELEVANT ICD-10 CODES for medical necessity per each test.

SEE commmonly used ICD10 codes at bottom of form.

LIST ICD-10 CODES BELOW:

1._____
2._____
3._____
4._____

ADDITIONAL TEST REQUEST:

_____
_____
_____
_____

Provider Signature:_____

3 RU_ALLERGIC?™ Custom Allergy Profiles

Please check the drop next to the profile defined in section 3 that you wish to run. Testing will only be conducted for the profiles that are checked."

Food Hypersensitivity Triggers

Discover how your diet impacts your health with our Food Hypersensitivity Triggers test! This test analyzes your immune response to 60 dietary antigens, identifying food hypersensitivities linked to digestive issues and fatigue. A simple blood test provides insights, empowering you to make informed dietary choices. Take the first step toward better health-get your Food Hypersensitivity Triggers test today!

Food Hypersensitivity Triggers +E

Discover how your diet impacts your health with our Food Hypersensitivity Triggers +E Test! This advanced blood test measures your IgG immune response and analyzes your immune response to 24 dietary antigens, helping identify food hypersensitivities that may contribute to digestive issues, fatigue, and other symptoms. A simple blood test provides insights, empowering you to make informed dietary choices. Take the first step toward better health-get your Food Hypersensitivity Triggers +E test today!

COMMONLY USED ICD-10 CODES. **These codes are provided as a convenience only; it is not a comprehensive list.**

Z91.010 Allergy to Peanuts
L27,2 Dermatitis due to ingested foods
29.70 Gastritis,unspecified
K59.00 Constipation,unspecified
R14.3 Flatulence
K90 89 Other intestinal malabsorption
L70.9 Acne, unspecified substance taken internally
Z91.012 Allergy to eggs

R19.7 Diarrhea, unspecified
J01.80 Other acute sinusitis
R53.82 Chronic fatgue, NOS
J45.32 Moderate persistent asthma w/status asthmaticus
J45.990 Exercise-induced brochospasm
J20.9 Acute bronchitis
J45.991 Cough variant asthma

J31.0 Chronic rhinitis
J30.1 Allergic rhinitis due to pollen
J01.40 Acute pansinusitis, NOW
J30.2 Other seasonal allergic rhinitis
J30.5 Allergic rhinitis due to food
J45.50 Severe persistent asthma, uncomplicated

4 PATIENT CONSENT

I authorize ClinLGX and/or its authorized agents, to run the specified tests on my blood sample and/or nasal swab. I understand that as a courtesy, ClinLGX and/or its authorized agents will make every reasonable effort to obtain reimbursement for ordered tests. I understand that I am making an assignment of my insurance plan benefits to ClinLGX and/or its authorized agents. I also authorize the release of any information contained in my records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. Bill to my insurance: I understand that if my insurance company pays me directly for services rendered by ClinLGX, I am responsible for forwarding such payment to ClinLGX. I also understand that I am responsible for any deductible/co-payment and coinsurance, or other obligations, as required by my plan and state laws.

PATIENT SIGNATURE:_____ DATE:_____

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