Place IDx barcode here
(Internal use only)

IntrinsicDx™
The BioIron Laboratory™

Laboratory Requisition Form

CLIA ID#: 05D2087906
CAP#: 8958850
Medical Director: William Paxton, MD, PhD, FACP
www.IntrinsicDx.com

Please print clearly and complete entire form. To avoid delays, include the completed form with your shipment.

PHYSICIAN INFORMATION (required)

IDx ACCT #: _____ *For returning Customer only. To set up an account, please contact IntrinsicDx.*

Last Name: _____ First Name: _____ MI: _____ NPI #: _____

Institution: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Ext: _____

Fax: _____ Email: _____ | Results by: ☐ Fax ☐ Mail

I certify that I have obtained informed consent in writing from the patient or their legal guardian to authorize IntrinsicDx to handle the patient's blood sample for above requested test and I understand that IntrinsicDx will only share the patients results with the requesting physician or their designee.

Physician Signature: _____ Date: _____

PATIENT INFORMATION (required)

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____ (MM / DD / YYYY)

Gender: ☐ Male ☐ Female | Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Ext: _____

Fax: _____ | Results by : ☐ Fax ☐ Mail

I hereby request that my test results may be reported to _____ *(Name of Person) by:* ☐ Fax ☐ Mail

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Ext: _____ Fax: _____

Patient Signature: _____ Date: _____

Family history of anemia? ☐ Yes ☐ No ☐ Unknown Recent oral iron challenge? ☐ Yes ☐ No If yes: ☐ Pos ☐ Neg Recent transfusion or IV iron? ☐ Yes ☐ No If yes, when: _____/_____/_____ (MM / DD / YYYY)

SAMPLE INFORMATION (required)

Date sample collected: _____/_____/_____ (MM / DD / YYYY) Time: _____:_____ AM/PM Initials: _____

Date sample shipped to IntrinsicDx: _____/_____/_____ (MM / DD / YYYY) Sample Type: ☐ Serum ☐ Li-Heparin-Plasma

View sample collection and shipping instructions at IntrinsicDx.com

TEST(S) REQUESTED/ORDERED (required)

☐ Hepcidin

Specify Diagnostic Code(s):

_____ _____ _____

_____ _____ _____

PATIENT BILLING INFORMATION (required)

Bill to: ☐ Insurance ☐ Physician ☐ Other: _____

If billing to insurance please attach a copy (front & back) of patient's insurance card(s) and complete all requested information below.

Primary Insurance Carrier: _____ Medicare, Medicaid or Policy ID #: _____

Insured's Name: _____ Insured's SSN: _____

Policy holder DOB: _____/_____/_____ (MM / DD / YYYY) Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Employer/Group Name: _____ Group #: _____

SECONDARY INSURANCE ☐ Yes *Please attach a copy (front and back) of patient's secondary insurance card.*

I hereby authorize IntrinsicDx to provide my designated insurance carrier, health plan or third party administrator (collectively "Plan") the information on this form and other information provided by my health care provider if necessary for reimbursement. I also authorize all benefits of the Plan to be payable to IntrinsicDx. If required by my Plan, I agree to assist in submitting appeals for payment, and understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient / Responsible Party Signature: _____ Date: _____

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