

Place IDx barcode here
(Internal use only)



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 Pos Neg Recent transfusion or IV iron? Yes No
If yes, when: ____/____/____
MM DD YYYY

SAMPLE INFORMATION (required)

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

Date sample shipped to IntrinsicDx: ____/____/____ Sample Type: Serum Li-Heparin-Plasma
MM DD YYYY (for either test) (for Heparin test only)

View sample collection and shipping instructions at IntrinsicDx.com

TEST(S) REQUESTED/ORDERED (required)

Heparin Erythroferrone 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: ____/____/____ Relation to Patient: Self Spouse Child Other: _____
MM DD YYYY

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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