IGEA RESEARCH

LAB PRESCRIPTION

Patient Name:_____ **Date of Birth:** _____

Address: _____

_____

Phone Number: _____ **Gender:** ❒**Male** ❒**Female**

Dx: _____ **Dx:** _____ **Dx:** _____

Description	Select √
ALZ-1 Free Copper (Non-Cp) in Serum	√

Physician Signature: _____ **Date:** ____/____/____

Physician Name: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Document in appropriate office records and/or hospital records each time a service is provided or ordered. In the case of laboratory test orders, the exact name of the test(s) being ordered needs to be in the patient's medical record.

IGEA Research Corporation
2600 SW 3rd Avenue, STE 350, Miami, FL 33129

ALZ-1 Non-Cp Copper Assessment Requisition Form

Last Revised: April 2016

____/____/_____
Date: (MM/DD/YYYY)

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Sex: F or M

Address

City | State | Zip Code

Home Phone | Date of Birth: (MM/DD/YYYY)

REFERRING AUTHORIZED PERSON

Name | Title/Specialty | NPI#

Clinic Name | Address

City | State | Zip Code

Phone # | Fax #

SPECIMEN COLLECTION INFORMATION

Time Collected: _____ (AM/PM)

Date Collected | Collected By

TEST SELECTION

☑ **ALZ-1 Non-Cp Copper Assessment**

DIAGNOSIS CODES (required as documentation that test requested is medically necessary):

_____ _____

_____ _____

_____ _____

PHYSICIAN NARRATIVE:

_____

_____

_____

_____

_____

_____

_____

_____

BILLING INFORMATION

(Please include a copy of the front and back of insurance card)

☐ **Commercial Insurance** ☑ **Self Pay** ☐ **Other:**_____

Primary Insurance Carrier

Insured's Name (if not patient) | Date of Birth: (MM/DD/YYYY)

Claims Address

Policy ID | Employer/Group Name | Group ID

PATIENT CONSENT AND ASSIGNMENT OF BENEFITS

I voluntarily request and consent to the laboratory testing that will be provided by IGEA Research Corporation ("IGEA"). I assign and transfer all rights, and interest in the benefits I may have under any insurance policy, health plan, or benefit plan (including but not limited to hospitalization, medical, third party liability insurance coverage, workers compensation benefits, employer health or wellness plan, or benefits paid by Medicare or Medicaid) ("Plan"), to IGEA with respect to any services IGEA provides. I designate IGEA as my authorized representative for any and all rights I may have under the Employee Retirement Income Security Act with respect to any services IGEA provides. I understand that I am responsible for any or all charges related to the laboratory tests provided by IGEA, including those charges not covered by my Plan and any patient cost sharing amounts, such as deductibles, co-insurance and co-pays as provided under the Plan, as well as any non-covered services. If my insurance provider does not pay for the laboratory tests provided by IGEA, I will be responsible for and I agree to pay the entire amount charged by IGEA for such laboratory tests. **I understand that the ALZ-1 Non-Cp Copper Assessment is currently not a covered service by many Plans.** I hereby consent to the use and disclosure of protected health information ("PHI") about me by IGEA for treatment, payment, and health care operations, and as otherwise required under applicable state and federal law. This consent includes my authorization to disclosure to the Plan (and its agents) by IGEA and other holders of PHI any relevant information about me for the purpose of determining payments by the Plan directly to IGEA for the services IGEA provides.

Signature of Patient | Name (print) | Date

HEALTHCARE PROVIDER SIGNATURE

By signing below, the Healthcare Provider confirms that:

1. I have explained the purpose of the test to the patient, and the patient has been given sufficient opportunity to become fully informed about the testing ordered.
2. I have determined that the test ordered is medically appropriate and is recommended by me, and the results will determine my patient's medical management and treatment decisions. I am authorized by law to order the test(s) requested herein, and I am aware that, in accordance with 42 CFR 493.1453, the IGEA clinical consultant is available at (305) 982-8831 to render opinions to me concerning the diagnosis, treatment and management of patient care.

Signature of Healthcare Provider | Name (print) | Date