Dunwoody Labs

REQUISITION FORM

Dunwoody Labs
9 Dunwoody Park, Suite 121
Dunwoody, GA 30338
678-736-6374
770-674-1701 (fax)

PROVIDER INFORMATION

I hereby authorize the laboratory to perform the test(s) selected as indicated below. If no boxes are selected, I understand that the sample will be placed on hold.
I understand and hereby acknowledge that I am ordering tests that I believe to be medically necessary for my patient and request the confirmatory and/or quantative tests accordingly.

Provider Name Printed:		Date:		Provider Signature:	

CLIENT TEST MENU

- ☐ Dietary Antigen Test 588G & 588E or
  - ☐ Dietary Antigen Test IgG w/Complement
  - ☐ Dietary Antigen Test IgE & IgG4 Molecules
- ☐ 588A: Dietary Antigen Test Secretory IgA
- ☐ 1000: Comprehensive Heavy Metal Urinalysis for Toxicity
- ☐ 1100: Female Hormones
- ☐ 1110: Male Hormones
- ☐ 1200: Complete Thyroid
- ☐ 1600: Advanced Adrenal Stress Test
- ☐ 2000: Female Wellness Panel
- ☐ 2100: Male Wellness Panel
- ☐ 2950: Basic Oxidative Stress (Urine Only)
- ☐ 2960: Advanced Oxidative Stress
- ☐ 4001: Neurotransmitters
- ☐ 4350: Amino Acids
- ☐ 4784: Lyme/Mold Panel (Serum, plasma)
- ☐ 5150: Advanced Intestinal Barrier Assessment *(DAO, Histamine, Zonulin, & LPS)*
- ☐ 5200: Comprehensive Stool w/Parasitology
  - ☐ Add on: Heliobacter pylori
- ☐ 6000: Oxidized LDL
- ☐ 6020: Airborne Allergy Test
- ☐ 6100: Complete Cardio w/OxLDL
- ☐ 7000: Comprehensive Screen
- ☐ **Individual Analyte/Other:**

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SPECIMEN INFORMATION

Collection Date:	

PRACTICE INFORMATION

NPI#:					
Clinic Name:					
Provider Name:					
Street Address:			City, State, & Zip:		
Phone:		Fax:		Email:	

PATIENT INFORMATION

DOB:		Sex:	Male ☐	Female ☐	
Last Name:		First Name:			
Street Address:		City, State, & Zip:			
Phone:		Fax:		Email:	

BILLING AND INSURANCE INFORMATION

Please attach a copy of the front and back of the patient's primary and secondary insurance card to this requisition.

Name on Credit Card:	
Card#	
Expiration Date:	-

- ☐ Clinician Pay
- ☐ Patient Pay
- ☐ Insurance Simple Pay Plan

In the event Insurance declines:

- ☐ I authorize Dunwoody Labs to charge the credit card provided the cash price for the test.
- ☐ I do not authorize my card provided to be charged, please cancel my test(s) ordered if insurance is not approved.

ASSIGNMENT OF BENEFITS AND CONSENT TO ACCESS TO LAB RESULTS

I authorize my insurance benefits to be paid directly to the lab for the services I have recieved. The lab is authorized to bill my insurance provider and to recieve payment of benefits for the tests my physicians ordered. I further authorize the lab and my physician to release my insurance provider any medical information necessary to this claim.

Patient Signature: ____________________________ **Date:** ________________

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Dunwoody Labs, as well as all employees, employers, representatives, and agents thereof, the balance due on my account for any professional services rendered and for any tests provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Dunwoody Labs for medical/healthcare services that have or will be rendered and for any tests provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your 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. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This document includes, but is not limited to, a designation that Dunwoody Labs can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Dunwoody Labs, myself, and/or my family members as a result of services rendered by Dunwoody Labs, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and/or designation will remain in effect unless revoked in writing, and a photocopy or scan is to be considered as valid and enforceable as the original.