Dr. Justin Marchegiani - www.JustInHealth.com - Office@JustInHealth.com - Office (512) 535-1817 - Fax (707) 227-1529

MOSAIC GLYPHOSATE TEST INSTRUCTIONS

What You Will Receive:

- A **prepaid UPS return label** (U.S. only)

  Tip: Save your tracking number if you'd like to confirm delivery to the lab

- Sample collection container
- Printed instructions from Mosaic Diagnostics

Before You Begin:

1. **Complete the attached requisition form** fully and clearly
   - Be sure to include the **date and time of urine collection**
   - Only use the **completed form** provided by our office
2. 🗑 Discard the blank form included in the kit
3. Review all urine collection instructions inside your test kit before beginning

On the Day of Collection:

- Follow the urine collection procedure included in your test kit
- Freeze the sample if instructed to do so
- **Include the completed requisition form** in your return shipment

  ⚠ Tests without completed forms will not be processed

Shipping the Sample:

- Use the **prepaid UPS label** to ship your sample
- Drop it off at any UPS location or schedule a pickup
- Ship as soon as possible after sample collection

What to Do Next:

1. Make sure you have a **consult scheduled with Dr. Justin** to review your results
2. **Lab results typically take 2–3 weeks**
3. For any kit or shipping questions, contact:
   - **Mosaic Diagnostics**: 800-288-0383 (Mon–Fri, 8 AM–5 PM CST)
   - **CustomerService@MosaicDX.com**

MOSAIC DIAGNOSTICS
Formerly Great Plains Laboratory

Place Test Kit ID sticker here.

Test Requisition Form (TRF)

Complete this paper Test Requisition Form **ONLY** if your test kit has **NOT** been registered by your practitioner.

How to know if you need to complete this paper TRF?

Step 1: Scan the QR code on the "Register Your Kit" guide included in your test kit.
Step 2: If your kit has NOT been registered you **CAN NOT** enter your information into the portal.
Step 3: You will need to complete the paper Test Requisition Form to submit with your sample.

All information is required to process sample. We do NOT accept specimens from patients who reside in or practitioners who practice in the state of New York.

Practitioner/Distributor Information

- If located within the U.S., your Practitioner will need to complete the below information.
- For outside the U.S., this section may be completed by either the patient, distributor or practitioner (if applicable).

First Name	Last Name	Credentials
Dr. Justin	Marchegiani	DC

Institution/Company	Phone	NPI (for U.S. Practitioners)
Just In Health	512-535-1817	1477828408

Address	Fax
2028 East Ben White Blvd Suite 240-2655	

City	State/Province	Zip/Postal Code	Country
Austin	TX	78741	United States

Email	Practitioner Signature (U.S. only)
office@justinhealth.com	☑ Practitioner Signature on File

ICD-10 Codes, U.S. only, required for insurance 1 -_____ 2 -_____ 3 -_____ 4 - _____

Distributor Information for International Clients

Distributor Company Name	Country	Email

Test Selection

PRACTITIONER MUST FILL OUT THE BELOW INFORMATION, if test is not selected, patient must go back to practitioners to complete this section, the patient cannot select additional tests on practitioner's behalf.

Urine Tests

Has urine been frozen? ◯ **Yes** ◯ **No**

Urine Collection Date (MM/DD/YYYY) _____ **Urine** Collection Time _____ AM / PM

- ◯ Organic Acids Test (OAT) (urine)
- ◯ MycoTOX Profile* (urine)
  - ◯ Patient is taking mycophenolate mofetil (CellCept/Myfortic)
- ☑ Glyphosate Test* (urine)
- ◯ GPL-TOX Profile* (urine)
- ◯ Microbial Organic Acids Test (MOAT) (included in OAT) (urine)
- ◯ Amino Acids Test* ◯ ***Random*** ◯ ***24 Hr*** Total vol _____ mL-
- ◯ Calcium + Magnesium Profile* (urine)
- ◯ Heavy Metals Test: ◯ ***Random*** ◯ ***24 Hr*** Total vol _____ mL
  - ◯ ***Timed*** # of hours _____ ◯ Pre-Provoking ◯ Post-Provoking
  - Provoking Agent _____ Dosage _____
- ◯ Kryptopyrrole Test* (U.S. only) (urine)
- ◯ Porphyrins Profile* (urine)

Blood / Dried Blood Spot (DBS) Tests

Blood Collection Date (MM/DD/YYYY) _____ **Blood** Collection Time _____ AM / PM

- ◯ IgG Food MAP with Candida + Yeast: ◯ Serum ◯ DBS
- ◯ IgE Food Allergy Basic Test (serum)
- ◯ IgE Food Allergy Advanced Test (serum)
- ◯ IgE Inhalant Allergy Basic Test (serum)
- ◯ IgE Mold Allergy Test (serum)
- ◯ Advanced Cholesterol Profile (serum)
- ◯ Amino Acids Test* (plasma)
- ◯ Copper + Zinc Profile (serum)
- ◯ Heavy Metals Test: ◯ Whole Blood ◯ RBC
- ◯ Homocysteine Test* (serum)
- ◯ Iron + Total Iron-Binding Capacity Test* (serum)
- ◯ Omega-3 Index Complete* (DBS)
- ◯ Streptococcus Antibodies Profile (serum)
- ◯ Vitamin D Test: ◯ Serum ◯ DBS

*** MosaicDX will not bill insurance for these test(s)**

Stool Tests

Stool 1 Collection Date (MM/DD/YYYY) _____ **Stool 1** Collection Time _____ AM / PM

Stool 2 Collection Date (MM/DD/YYYY) _____ **Stool 2** Collection Time _____ AM / PM

- ◯ Comprehensive Stool Analysis with Parasitology
- ◯ Microbiology Test (stool)
- ◯ Heavy Metals Test (stool)
  - ◯ Pre-Provoking ◯ Post-Provoking
  - Stool Provoking Agent _____ Dosage _____
  - Does patient have dental amalgams?
  - ◯ No ◯ Yes, how many? _____

Saliva Tests

Saliva Collection Date (MM/DD/YYYY) _____ Collection Time Morning _____

Collection Time Noon _____ Collection Time Evening _____ Collection Time Night _____

Has saliva been frozen? ◯ **Yes** ◯ **No**

Check applicable: ◯ Hysterectomy ◯ Ovaries removed

1st Day of Last Menstrual Period (MM/DD/YY) _____

- ◯ Hormone Comprehensive Profile (saliva)
  Estradiol, Progesterone, Testosterone, DHEA, 4x Cortisol
- ◯ Hormone Comprehensive Plus Profile (saliva)
  Estrone, Estradiol, Estriol, Progesterone, Testosterone, DHEA, 4x Cortisol

Hair, Water, and Other Tests

Buccal Swab Collection Date (MM/DD/YYYY) _____

- ◯ DNA Methylation Pathway Profile* (buccal)
  (requires Informed Consent form)

Hair/Other Collection Date (MM/DD/YYYY) _____

- ◯ Heavy Metals Test (hair)
- ◯ Glyphosate Test* (water)
- ◯ Other test: _____

Patient and Payment Information

First Name | Last Name | Age | Weight

Sex: ◯ Male ◯ Female | Birth Date (MM/DD/YYYY) | Phone Number | Language Preference for Results

Not all results are available in every language. If preferred choice is not available, you will receive results in English.

Address

City | State/Province | Zip/Postal Code | Country

Email

I authorize and request payment of medical benefits be made directly to the guarantor listed for requested lab work. I authorize the release of any medical information necessary to file and process an insurance claim, if applicable. I understand that certain tests are not billable to insurance (self-pay tests) thus Mosaic Diagnostics will not file a claim for these tests. Person responsible for charges authorizes Mosaic Diagnostics to process payment in full for tests requested (plus all applicable filing fees). I understand Mosaic Diagnostics does not guarantee insurance coverage by filing a claim. I permit a copy of this to be used in place of the original. Cancellation Policy: I have reviewed and agree to the cancellation policy located at www.mosaicdx.com/cancellation-policy.

Signature: _____ **Date:** _____

Person Responsible for Charges ☑ **Same as Patient**

First Name | Last Name

Address | Phone Number

City | State/Province | Zip/Postal Code | Country

Email

☑ **Bill Practitioner:** Dr. Justin Marchegiani unavailable for practices in New Jersey, New York, or Rhode Island

◯ **Patient Pay** more information is available at www.MosaicDX.com/payments

- ◯ Pay online at www.MosaicDX.com/payments Transaction ID#: _____
- ◯ Charge my credit card Card # _____

  Exp Date _____ Security Code _____ Billing Zip/Postal Code _____

  Name on Card _____ Signature _____
- ◯ Check
- ◯ Wire Transfer, an additional $40 is required to be paid as bank commission. Please include the inbound shipping charges. Email a copy of your wire transfer receipt to wiretransfers@mosaicdx.com.
- ◯ PayPal, send payment to "payment@mosaicdx.com". Your PayPal user name: _____
- ◯ International Shopping Cart Pre-Paid 4-Digit Confirmation # _____–INT

  Person who bought test: First Name _____ Last Name _____

See other side to fill out Insurance Information (U.S. only)

Insurance Information

◯ **Bill Insurance** – U.S. only *Include photocopy of both sides of insurance card.*

We require full patient cash price payment up-front PLUS a $40 filing fee per claim to be submitted along with the sample. After we have filed a claim on the patient's behalf, any insurance payment corresponding to the claim will be sent directly to the patient from the insurer. For questions, please call 913-754-0459.

Primary Insurance Company and Plan Name (ex. BCBS of Kansas City): _____

Insurance Company Address: _____

Insurance Company Phone: _____ Name of Policy Holder: _____

Policy Holder Date of Birth (MM/DD/YYYY): _____ Subscriber #: _____

Patient Relationship to Policy Holder: _____ Group Number: _____

Secondary Insurance Company and Plan Name (ex. BCBS of Kansas City): _____

◯ I acknowledge Mosaic Diagnostics is not a participating provider in Medicare or Medicaid. I understand if Medicare or Medicaid is my primary insurance carrier, I will be considered "self-pay" and agree I will not submit my claim to my insurance.

Visit www.MosaicDX.com/payments to find the entire insurance overview.
For questions about insurance, please call 913-341-8949. Contact your practitioner for test pricing.

Insurance Filing
Mosaic Diagnostics will file an insurance claim for qualifying tests on behalf of the patient for a $40 filing fee per claim (see list of qualifying insurance plans at www.MosaicDX.com/payments). Mosaic Diagnostics requires full patient cash price payment up-front PLUS a $40 filing fee per claim to be submitted along with the sample. After Mosaic Diagnostics has filed a claim on the patient's behalf, any insurance payment corresponding to the claim will be sent directly to the patient from the insurer.