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

GENOVA METABOLOMIX TEST INSTRUCTIONS

What You'll Receive:

- Sample collection container (urine + blood spot)
- Detailed collection instructions
- **Prepaid FedEx return envelope**

Before You Begin:

1. Use the **correct requisition form** labeled for the **Metabolomix test (cash pay only)**

   ☑ Patients not using insurance should use this version

2. **Complete all required fields** on the form

   🔓 Leave insurance and credit card info blank

3. **Samples submitted without a requisition form will be discarded**

Sample Collection Steps:

1. Urine Sample

- Follow the instructions provided in the kit
- After collection, **freeze the sample for at least 24 hours**

2. Blood Spot Collection

- Follow the steps for collecting a blood spot on the card
- **Let the card air dry completely for 24 hours**

  ⚠ Moist or damp cards may result in an invalid sample

Shipping Instructions:

- Once urine is frozen and blood spot is dry:
    1. Place all samples in the cardboard box
    2. Insert the **completed requisition form**
    3. Seal the box and place it in the **FedEx return bag**
- Ship using **FedEx drop-off** or schedule a **FedEx pickup** as soon as samples are ready

Important Notes:

- All **samples and the completed requisition form** must be shipped together

  ⚠ *Missing forms will result in the sample being discarded and additional fees*
- You do **not** need to fast or stop supplements unless instructed otherwise

What to Do Next:

1. Make sure you have a **consultation scheduled** with Dr. Justin
2. Results typically arrive in **3–4 weeks**
3. Dr. Justin will review your test and update your protocol during your appointment

Questions?

For questions about collection or shipping, contact **Genova Diagnostics** at **(800) 522-4762**

Activate Online And Return This Form
www.gdx.net/activate *By activating online, you do NOT need to fill out this form, but you must return it for processing.*

GENOVA DIAGNOSTICS

Phlebotomy Code P C

Requisition *Full Option*

697-245-81

GDX ID# **A65E0**
Just In Health
Justin Marchegiani, DC
2028 E Ben White Blvd # 240-2655
Austin, TX 78741-6966
512-535-1817
NPI: 1477828408

Specimens for patients less than 2 years of age will be discarded.

Date Final Sample Collected: Mo. Day Year

Sample Type:
Urine, First Morning Void and Bloodspot

#103

X Metabolomix+ #3200 IIP 150 CP 310

Profile Components	CPT Codes	Other / MC
___Organic Acid Markers		
Creatinine, Urine	82570	
Citric Acid	82507	
Lactic Acid	83605	
Pyruvic Acid	84210	
Vanilmandelic Acid	84585	
5-OH-Indoleacetic Acid	83497	
Homovanillic Acid	83150	
D-Arabinitol	84311	
Oxalate	83945	
Organic Acids	83921	x 19 / 2
___Amino Acid Analysis, Urine	82139	
___Lipid Peroxides, Urine	84311	
___8-OHdG	82542	

Profile components available individually on separate requisitions.

Add-on Tests

____Essential and Metabolic Fatty Acids - Bloodspot #3202 IIP 10 CP 35

Essential & Metabolic Fatty Acids	82542
Behenic Acid	82726
Docosatetraenoic Acid	82726
Lignoceric Acid	82726
Nervonic Acid	82726
Tricosanoic Acid	82726

IMPORTANT! Please choose between the Toxic Elements Clearance or the Comprehensive Urine Elements. Both cannot be selected.

____Toxic Elements Clearance #3203 IIP 10 CP 35

Aluminum	82108
Antimony	83018
Arsenic	82175
Barium	83018
Bismuth	83018
Cadmium	82300
Lead	83655
Mercury	83825
Nickel	83885

____Comprehensive Urine Elements #3204 IIP 20 CP 70

Comprehensive Urine Elements includes all the markers in the Toxic Clearance Profile, plus the two listed below.

Calcium	82340
Magnesium	83735

Genomic Add-ons

Genomic markers are not billable to Medicare or other insurance carriers. Please include a payment method for the full cost of each genomic marker, if applicable.

☐	MTHFR (C677T & A1298C)	IIP 35 CP 35
☐	COMT (V158M)	IIP 35 CP 35
☐	APOE	IIP 35 CP 35
☐	TNF-a	IIP 35 CP 35

The Metabolomix+ profile is not currently available in New York State

Clinical Findings/Clinical Impressions:

X Justin Marchegiani

Authorizing Provider Signature & Date *(required)*

Please document medical necessity and the specific order for the test in the patient's medical record or progress notes with a signature and date from the referring physician in addition to providing a diagnosis code below.

Definition of Medical Necessity

All claims submitted to Medicare/Medicaid for Genova Diagnostics' laboratory services must be for tests that are medically necessary. "Medically necessary" is defined as a test or procedure that is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Consequently, tests performed for screening purposes will not be reimbursed by the Medicare program. Physicians may deem it medically necessary to order a single test or a portion of a profile.These guidelines are also contained in Genova's electronic ordering system, where all orders for Medicare beneficiaries must be submitted.

Billing Options

Check only one option below. If no billing option selected, practitioner account may be billed.

Medicare or Tricare Order
Medicare & Tricare orders **MUST be registered online BY THE PRACTITIONER at** www.gdx.net/activate **and cannot be submitted with a paper requisition.**
If not registered online, **THE SPECIMEN WILL BE DISCARDED**. DO NOT write Medicare on this requisition and expect that Genova can process it.
Medicaid patients- use No Insurance options.

X **Bill Practitioner Account** *Complete on reverse:* 1
Not available in the states of NY, NJ, and RI

☐ **Bill Insurance with Patient Payment*** *Complete on reverse:* 1 2 3 4
Medicare Advantage patients – use Bill Insurance with Patient Payment.
Initial Insurance Payment from Patient: $_____

No Insurance Billing - (Cash Pay)* *Complete on reverse:* 1 3 4
☐ *Pre-payment- please include full Cash Price amount* **Amount Enclosed: $_____**
☐ *Payment plan- please include 25% of the Cash Price amount** **Initial Installment: $_____**

**For payments & pricing please visit www.gdx.net/pay or ask your healthcare practitioner.*

Potential ICD-10 Codes and Conditions

IMPORTANT:
Please select or add the appropriate ICD-10 diagnosis code(s).

___ R53.83 Other Fatigue
___ E63.9 Nutritional Deficiency, Unspecified
___ F41.9 Anxiety Disorder, Unspecified
___ E61.9 Deficiency Of Nutrient Element, Unspecified
___ G47.9 Sleep Disorder, Unspecified
___ L30.9 Dermatitis, Unspecified
___ R53.82 Chronic Fatigue, Unspecified
Other Codes:_____

CPT & ICD-10 Codes
Due to the possibility of regulatory and/or methodology changes, CPT and ICD-10 codes are subject to change without prior notification.

THIS SPACE FOR LAB USE ONLY

69724581

Save time by completing this form at www.gdx.net/activate

Enter your online confirmation code: _____

OR Refer to the billing options on the front and fill in the required sections below. *(Please use black or blue pen).*

1 Patient Information Section *Required for all patients.*

Full SSN required for insurance billing and online access to your test results.

Patient Date of Birth mm/dd/yyyy: __ __ - __ __ - __ __ __ __ **Sex:** M F **Social Security #:** __ __ __ - __ __ __ - __ __ __ __

Patient Name (last): (first): (middle):

Mailing Address:

City: **State:** **Zip:** -

Cell Phone: **County:** **Country:**

Alternate Phone: **Race:** American Indian/Alaskan Native Asian Black/African-American Native Hawaiian/Pacific Islander White Multiracial Other Unknown

Email:

Responsible Party Name: *(Other legal guardian or if patient is a minor child)* **Ethnicity:** Hispanic Non-Hispanic Other Unknown

Name (last): (first): (middle):

If you reside in OH or NH, the following fields are required:

Occupation: _____ Employer Address: _____

Employer: _____ _____

2 Insurance Information Section *Required only for patients who want a claim filed to their insurance.*

List your primary insurance information here. Include copies of all your health insurance cards to ensure accurate claim filing.

Medicare/Tricare patients, please ensure your physician completed this order online to prevent your specimen from being discarded.

(Print clearly)

Insurance Company: _____ Subscriber Name: _____

Please include front/back copy of all health insurance cards

Subscriber ID #/Medicare #: _____

Claims Address: _____ Group #: _____

City/State/Zip: _____ Subscriber Date of Birth: (mm/dd/yyyy) _____

Phone #: _____ Relation to Patient: ❑ Self ❑ Spouse ❑ Other _____

Please note: We do not participate with Medicaid. All Medicaid patients should use the no insurance option.

3 Payment Section *For Bill Insurance / No Insurance.*

Visit www.gdx.net/pay for additional details and to make your payment online!

Bill Insurance Option

If choosing to have us bill your commercial insurance or Medicare Advantage plan, **please follow the steps below to qualify for the lowest out of pocket cost.**

1. **Submit required Initial Insurance Payment** by completing the payment section at right.
2. We will bill a claim to your insurance and **you will receive a billing summary statement if there is an additional amount due.**
3. **Act promptly and pay by the date indicated on your statement. Applicable discounts will expire.**

No Insurance Option (Cash Pay)

Complete the payment section to the right and provide the Cash Price in one of two ways:

1. **Full Pre-Payment**
2. **Payment Plan (for tests $100 or higher)**
   - 25% of cash price (including add-ons) due now
   - Remaining amount charged to credit card provided in 3 equal installments

Payment from: ❑ Practitioner ❑ Patient

Payment type: ❑ Payment online: *(Patient only)* **www.gdx.net/pay** 6-Digit Confirmation Code

❑ Check #_____ Amount: $_____

Make checks payable in US dollars to Genova Diagnostics

❑ Credit Card Authorized Amount: $ _____

(Print clearly)

Credit Card #:

Background color is for security purposes

Expiration Date: ____/____ CVV: _____

Cardholder Signature: _____

Printed Name: _____

Card Holder's Billing Zip Code: _____

For more payment information, visit our website: **www.gdx.net/pay**. Your practitioner will also have the payment information on their lab fee schedule.

4 Patient/Responsible Party Acknowledgement *Please read and sign below.*

I have read the Billing Guidelines and I understand my responsibilities as described within them.

Except in the case of pre-payment I authorize the payment of all medical benefits to be paid directly to Genova Diagnostics and authorize the release of any medical information required for my health plan to process/pay claims resulting from my testing services. I understand that Genova Diagnostics is likely an out of network provider with my health plan. I acknowledge my out of network financial responsibility per my plan benefits and according to the applicable billing guidelines. If Genova Diagnostics participates with my health plan: 1) I acknowledge that payment will be applied toward the patient responsibility after my health plan has processed the claim, and 2) I understand that the tests on the front of this form may be deemed not medically necessary, experimental, or investigational by my health plan and authorize the services to be performed and to be financially responsible for the cash price described in the company's fee schedules.

Medicare Patients should refer to the Advanced Beneficiary Notice document in the collection pack (if applicable) related to medical necessity for certain tests.

I authorize Genova Diagnostics to act as my representative in any claim appeal process. I permit a copy of this requisition to be used in place of the original.

Under the General Data Protection Regulation (GDPR) issued by the European Commission, Genova Diagnostics is a third-party processor of that Customer Personal Data; the above signed Practitioner/Clinician is a controller and/or processor, as applicable, of that Customer Personal Data under the European Data Protection Legislation; and each party will comply with the obligations applicable to it under GDPR Legislation with respect to the processing of that Customer Personal Data. Genova Diagnostics is permitted to process Customer Personal Data only in accordance with applicable law: (a) to provide the services as designated above and related technical support; (b) as further specified via Customer's use of the Services; (c) as documented in the form of the applicable Agreement, including this Data Processing Amendment; and (d) as further documented in any other written instructions given by Customer and acknowledged by Genova Diagnostics as constituting instructions for purposes of this Data Processing Amendment. The customer should contact the provider of record for details regarding the scope of processing agreement and subject's personal data rights.

Patient/Responsible Party Name: _____ Date: _____

Signature (required): _____ *QUESTIONS? 1-800-522-4762*

5 Visit Your Patient Resource Center

• Access test results • Make payments • Complete health surveys

Log On At: **www.gdx.net/prc**

GENOVA DIAGNOSTICS | 63 Zillicoa Street Asheville, NC 28801 | 800.522.4762 www.GDX.net

Patient Guide

Metabolomix+

#3200

Abnormal kidney function or use of diuretics may influence test results.

Do not collect if there is blood in urine, including menstrual or other blood.

Valproic acid, acetaminophen and berberine HCl are direct assay interferants for certain analytes.

BEFORE YOU BEGIN

Activate This Test

Visit **gdx.net/activate** and enter the number found on the Activation Label Card included with this collection pack.

STEP 1

Plan Your Collection

Use a calendar to plan your specimen collection. Ship Monday thru Friday and avoid US holidays which may cause delays.

4 Days before Collection

Consult your healthcare provider about stopping medications and supplements.

24-Hours Before Collection

Freeze freezer brick at least 8 hours.

Eat usual diet but avoid over-eating any single food or consuming an extreme diet.

Consume no more than six 8-ounce glasses of fluid over the 24 hours before collection.

Night Before Collection

Fast overnight. Water is okay.

If collecting cheek swab, brushing and flossing are okay but do not use mouthwash.

Morning of Collection

Do not practice normal oral hygiene, use mouthwash, eat, or drink anything other than water before collection.

Collect urine, cheek swab (if ordered), and bloodspot (if ordered) immediately upon waking.

24 Hours After Collection

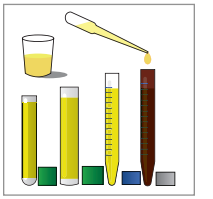
Ensure urine tubes have been frozen and bloodspot card has dried for at least 24 hours before returning.

STEP 2

Specimen Collection

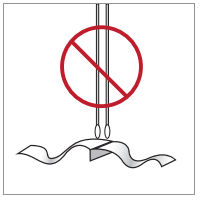
1. **Review** instructions from your healthcare provider at **gdx.net/activate**.
2. Write your **date of birth** (DOB) and the **date of collection** on the labels provided. Attach a completed label to each of the **four urine tubes**. Attach a completed label to the **blood spot card** and **paper swab envelope** if your healthcare provider has ordered those collection types.

Collect Urine



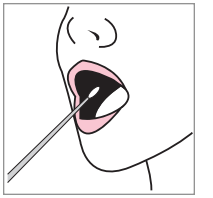
1. **Collect** your **first morning urination** in the provided cup. If you wake to urinate during the night, within 6 hours of when you typically wake for the day, collect your urine **in the cup**, refrigerate, then combine with your first morning urination collection.
2. **Stir**, then **transfer** urine from the cup to **each of the four tubes** using the pipette. Continue to add urine until each tube is nearly full.

   Avoid Contact with skin and eyes. For eye contact, flush with water thoroughly for 15 minutes. For skin contact, wash thoroughly with soap and water. If ingested, contact a poison control center immediately.

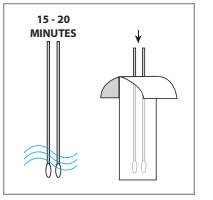


3. **Recap** the tubes tightly and **shake**.
4. **Return** the tubes and absorbent pad to the biohazard bag and **freeze** for at least 24 hours. The **freezer brick** must be frozen at least 8 hours.

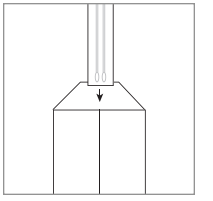
Collect Cheek Swabs (if ordered)



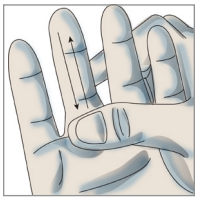
1. **Peel** open the **cotton tipped applicators** just enough to remove the cotton swabs. Leave the package intact so that the swabs can be reinserted after collection.
2. **Remove** one cotton swab applicator. **Do not touch** the cotton tip.
3. **Open** your mouth and **aggressively scrape** the inside of your cheek with the cotton swab using a back and forth, and up and down motion for at least **30 seconds**. **Rotate** the applicator several times, and swab between the cheek and gums. **Avoid excessive saliva**.

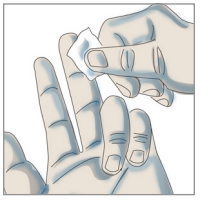


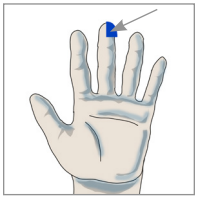
4. **Repeat steps 2 and 3 with the second swab.**
5. Allow swab applicators to **air dry** for 15–20 minutes. **Return** them, swab first, to the applicator package. **Seal** package inside the paper envelope.

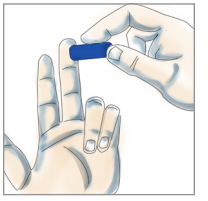


Collect Blood Spots (if ordered)









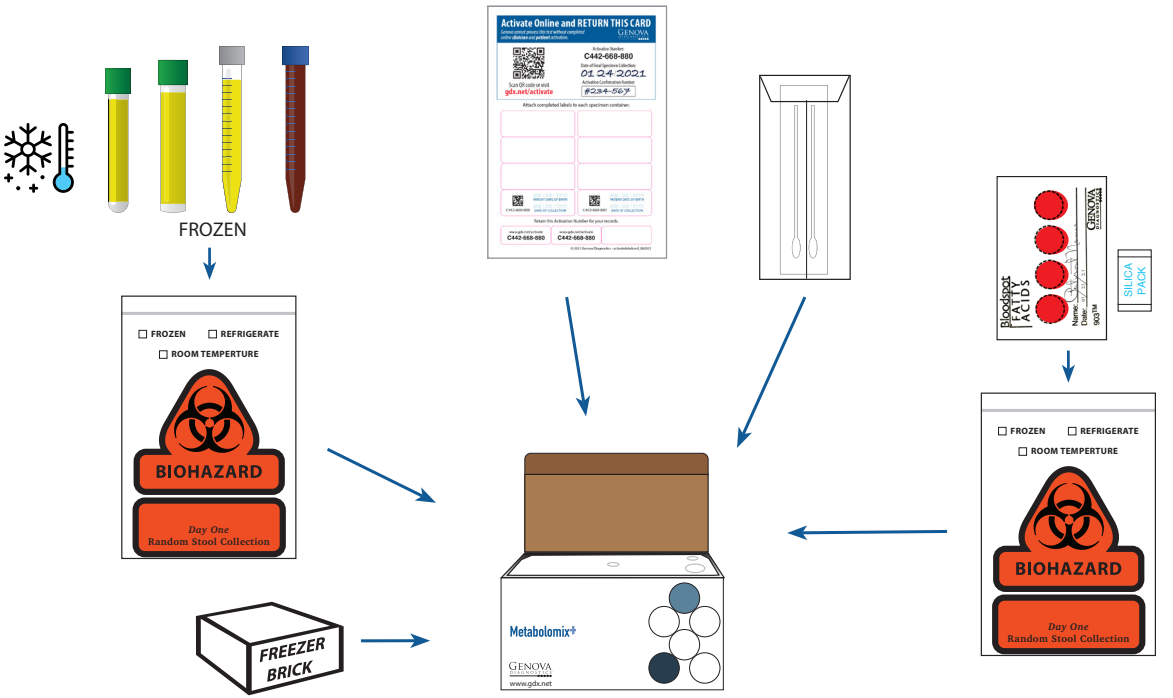
1. **Wash** hands with warm water for at least 20 seconds. Dry hands.
2. To improve circulation:
   - Hold your hand lower than heart level and gently massage the entire length of the middle finger for 30 seconds.
   - Firmly grasp the top knuckle of the middle finger for a few seconds.
   - Hang arm down and gently shake your fingers.
3. **Clean** the tip of your finger with the alcohol pad.
4. **Remove** clear cover from the lancet. One end has a small hole in the center; **press** that end firmly against the appropriate location on your middle fingertip (see image) to engage the lancet.
5. Using your thumb, **gently massage** the entire length of the pricked finger to form blood drops. **Touch** the tip of each drop to a circle on the collection card. **Do not smear**. It is important you **do not touch your fingertip to the card**. Continue until blood has soaked to the border of the circle.

6. **Continue** this procedure until all four circles are filled. **If you are unable** to get enough blood from the first collection, repeat this procedure with a different finger.
7. Allow the collection card to **air dry 24-hours** then return to the biohazard bag with absorbent silica pack. If the card is not completely dry, your sample may be unusable.

STEP 3

Return Collection Pack

1. Confirm that each tube has a **completed label attached** with **date of birth** and the **date of collection**. Place the **frozen freezer brick** and the biohazard bag with **frozen tubes** inside the **foam insulator**. Replace the foam lid.
2. If ordered, place the **cheek swab envelope** and the biohazard bag with **bloodspot card** and absorbent silica pack behind the foam insulator inside the cardboard box. Ensure that each specimen has a **completed label attached**.
3. Visit **gdx.net/activate** to enter the date of your final collection and receive your **confirmation code**. Write the date of final collection and your confirmation code on the **activation label card** and place on top of the foam insert.
4. **Close** the **cardboard box** and **place** inside the **FedEx shipping bag**. Follow the shipping instructions provided.



Additional resources are available online.
Visit **gdx.net/activate** and enter your activation number.