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

GENOVA NUTREVAL FMV TEST INSTRUCTIONS

What You'll Receive:

- Sample collection materials (urine and blood)
- Detailed instructions from Genova
- **Prepaid FedEx return envelope**

Before You Begin:

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

   ☑ For patients not using insurance

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

   🔒 Leave insurance and credit card sections blank

3. **Samples without the requisition form will be discarded**

Sample Collection Steps:

1. Urine Collection

- Follow the kit instructions carefully
- After collection:
  - Place tubes and absorbent pad in the **biohazard bag**
  - **Freeze the urine sample for at least 2 hours**
  - **Freeze the freezer brick for at least 8 hours**

2. Blood Draw

- Schedule a blood draw with a **phlebotomist or draw site**
- Bring the **cardboard box** and **FedEx return materials** to your appointment
- The lab technician will place the completed blood draw materials in the box for shipping

Shipping Instructions:

- Make sure both urine and blood samples are packed **together**
- Include the **completed requisition form** in the return package
- Use the **prepaid FedEx shipping label**
- Ship the same day or as soon as samples are ready
  - Make sure frozen materials stay cold—use the freezer brick as instructed

Important Notes:

- This is a **cash-pay test** only
- All specimens **must be shipped together** with the requisition form
  - ⚠ *Missing forms will result in your sample being discarded and may require repurchase*

What to Do Next:

1. Be sure your follow-up **consult is scheduled** with Dr. Justin
2. **Results take 3–4 weeks** from the date the lab receives the sample
3. Dr. Justin will review your results and protocol in detail during your appointment

Questions?

For shipping or test-related concerns, 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*

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

Date Final Sample Collected: Mo. Day Year

Sample Type: Fasting Blood, Urine (First Morning Void) and Buccal Swab

#86

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

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
___ E61.9 Deficiency Of Nutrient Element, Unspecified
___ E63.9 Nutritional Deficiency, Unspecified
___ F41.9 Anxiety Disorder, 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.

X **NutrEval (FMV) #3000** IIP 179 CP 415
with Nutrient & Toxic Elements

Profile Components	CPT Codes	Other / MC
___Organic Acids Markers		
Creatinine, Urine	82570	
Citric Acid	82507	
Lactic Acid	83605	
Pyruvic Acid	84210	
Vanilmandelic Acid	84585	
Homovanillic Acid	83150	
5-OH-Indoleacetic Acid	83497	
D-Arabinitol	84311	
Oxalate	83945	
Organic Acids	83921	x 19 / 2
___Essential & Metabolic Fatty Acids	82542	
Behenic Acid	82726	
Docosatetraenoic Acid	82726	
Lignoceric Acid	82726	
Nervonic Acid	82726	
Tricosanoic Acid	82726	
___Amino Acids Analysis, Urine	82139	
___8-OHdG	82542	
___Glutathione	82978	
___Lipid Peroxides, Urine	84311	
___Coenzyme Q10 (Ubiquinone)	82542	
___Nutrient & Toxic Elements		
Arsenic	82175	
Cadmium	82300	
Copper	82525	
Lead	83655	
Magnesium	83735	
Manganese	83785	
Mercury	83825	
Potassium	84132	
Zinc	84630	

Add-on Tests

___	Vitamin D	82306	IIP 10 CP 35

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

Profile components available individually on separate requisitions.

NutrEval Profiles are not currently available in New York State

Clinical Findings/Clinical Impressions:

THIS SPACE FOR LAB USE ONLY

69724631

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: _____

Please include front/back copy of all health insurance cards

Claims Address: _____

City/State/Zip: _____

Phone #: _____

Subscriber Name: _____

Subscriber ID #/Medicare #: _____

Group #: _____

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

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

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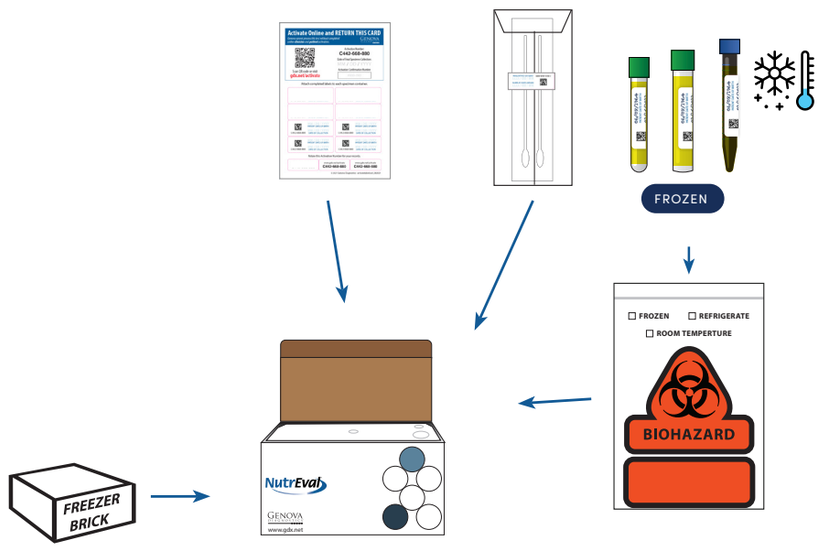
REV:1019

STEP 3

Add to 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, confirm the **cheek swab envelope** is sealed shut and has a **completed label attached. Then place** behind the foam insulator inside the cardboard box.
3. Retain a copy of the **activation number** for future reference **using one of the three labels provided on the bottom of the activation label card.**
4. Visit **gdx.net/activate** to enter the date of your final collection and receive your **confirmation code**. Write the date of collection and your confirmation code on the **activation label card.** Place the **activation card inside** the box.
5. Bring the **cardboard box** and the **FedEx shipping materials** with you to your blood draw appointment.



GENOVA DIAGNOSTICS

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

Patient Guide

NutrEval FMV amino acids

NutrEval® FMV #3000*

Not Available in New York

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

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

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

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.

Freeze freezer brick at least 8 hours.

Use your normal nightly routine of brushing and flossing of teeth, but do not use mouthwash.

Morning of Collection

If collecting cheek swab - do not eat, brush or floss your teeth, use mouthwash, chew gum or use any tobacco, or coffee products. You may drink ONLY water before specimen collection.

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

STEP 2

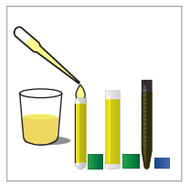
Specimen Collection

1. **Review** instructions and test prep information 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 **three urine tubes**. Attach a completed label to the **paper swab envelope** if your healthcare provider has ordered the swab collection.

Collect Urine

1. **Collect** your **first morning urination** in a clean container (a large plastic cup works well). If you wake to urinate during the night, within 6 hours of when you typically wake for the day, collect your urine **in the container**, refrigerate, then combine with your first morning urination collection.
2. **Stir**, then **transfer** urine from the cup to **each of the three 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 a minimum of 2 hours. The **freezer brick** must be frozen at least 8 hours.



Collect Cheek Swabs (if ordered)

1. **Peel** open the **cotton tipped applicator package** 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.