GENOVA DIAGNOSTICS

Phlebotomy Code P C

Date Final Sample Collected:
Mo. Day Year

Sample Type: Breath

Requisition

Full Option

#592-441-6

Note: This form must be completed (including responsible party signature) and returned with specimen in order to process this test.

#55

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

___ **Small Intestinal Bacterial Overgrowth (SIBO)-2hr #2306** IIP 109 CP 179

Profile Components/CPT Codes

Hydrogen and Methane Breath Test	91065

X **Small Intestinal Bacterial Overgrowth (SIBO)-3hr #2337** IIP 109 CP 179

Profile Components/CPT Codes

Hydrogen and Methane Breath Test	91065

X Justin Marchegiani

Physician's 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.

Billing Options

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

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

Please Record Your Collection Times in the Blank Fields

Specimen Intervals	RECORD COLLECTION TIMES hours/min	circle one	Example
SAMPLE 1 @ **0 min**		AM or PM	8:00 AM
SAMPLE 2 @ **20 min**		AM or PM	8:20 AM
SAMPLE 3 @ **40 min**		AM or PM	8:40 AM
SAMPLE 4 @ **60 min**		AM or PM	9:00 AM
SAMPLE 5 @ **90 min**		AM or PM	9:30 AM
SAMPLE 6 @ **120 min**		AM or PM	10:00 AM
ONLY COLLECT/RECORD TIMES BELOW FOR THE SIBO 3 HOUR TEST			
SAMPLE 7 @ **150 min**		AM or PM	10:30 AM
SAMPLE 8 @ **180 min**		AM or PM	11:00 AM

Potential ICD-10 Codes and Conditions

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

___ K58.0 Irritable Bowel Syndrome With Diarrhea
___ K58.9 Irritable Bowel Syndrome Without Diarrhea
___ R10.84 Generalized Abdominal Pain
___ R10.9 Unspecified Abdominal Pain
___ R14.0 Abdominal Distension (Gaseous)
___ R14.1 Gas Pain
___ R14.2 Eructation
___ R14.3 Flatulence

Other Codes: K59.9

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.

Clinical Findings/Clinical Impressions:

THIS SPACE FOR LAB USE ONLY

5924416

Please complete indicated sections below as referenced in Billing Options on requisition front. (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

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

(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.*

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) **https://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: **https://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 the tests listed on the front of this form may be out of network for my health plan and acknowledge my 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: **https://www.gdx.net/prc**

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

5924416155

REV:1019

IMPORTANT PREP BEFORE PATIENT TAKES TEST

2-4 WEEKS BEFORE THE TEST:

- ❑ Wait 4 weeks from your last dose of antibiotics, colonoscopy or barium enema.
- ❑ Wait at least 2-4 weeks from your last dose of antifungals, Pepto-Bismol™ or herbal/natural antimicrobial products.

7 DAYS BEFORE THE TEST:

- ❑ **Avoid the use of laxatives**, stool softeners, and/or stool bulking agents as well as antacids containing aluminum or magnesium hydroxide.

24 HOURS BEFORE THE TEST:

- ❑ **Foods you CAN eat before you start your 12 hour fast**: Baked or broiled chicken, fish or turkey (salt and pepper only),white bread (only), plain steamed white rice, eggs, clear chicken or beef broth with no vegetable pieces, water, plain coffee, or tea (no sugar/ artificial sweeteners or cream).
- ❑ **Vegetarians** may have tofu with salt and pepper.
- ❑ **Do not take probiotics.**

12 HOURS BEFORE THE TEST:

- ❑ **Fast for 12 hours prior to the test**. Do not eat or drink anything other than water for 12 hours prior and during the test.
- ❑ **Do not take non-essential medications or supplements** until the test is completed, unless your physician has advised you otherwise. Do not chew gum, eat candy, or use mouthwash until the test is completed.

1 HOUR BEFORE THE TEST:

- ❑ **No smoking,** including second-hand smoke, for at least 1 hour before or at any time during the breath test.
- ❑ **No sleeping** or vigorous exercise for at least 1 hour before or at any time during the breath test.
- ❑ **Do Not Use Toothpaste.**

Important Things To Know And Consider:

This test uses lactulose; since lactulose contains galactose and lactose, it is not recommended for individuals who have had allergic reactions to lactulose, or who are on a galactose/ lactose-restricted diet. It should be used with caution in diabetics.

Special Instructions for patients weighing 100 pounds or less: Follow the instructions on the blue bag for rolling and stapling the bag in accordance with weight. (Note: stapling will not damage the bag or affect the results).

Do not open, remove, or loosen tops of collection tubes–this will break the vacuum and make it impossible to perform your test. **Do not stick your finger** into the mouthpiece/plastic bag – there is a sharp needle inside.

We do not suggest collecting during an acute infectious illness.

This collection is extremely time-sensitive. You need to carefully plan the morning around these timed collections. An uninterrupted 2 or 3 hours is ideal.

Use the Breath Collection Schedule Table on the front of the Requisition to help you schedule your collection times. **Be sure you fill in the Table as the test progresses.**

BREATH COLLECTION

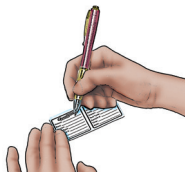
For full details refer to: www.gdx.net/tests/prep (collection video available)

To ensure accurate test results you must provide the requested information.

1. **Write patient's first/last name and the tube number** (1 - 6 (or 8) in order of collection) on the tube labels provided. **Write patient's first/last name, date of birth, gender and date of collection** on the Test Requisition Form.

2. **Stir** the Lactulose solution into 8 ounces of water. Set aside until after you have completed your first breath collection. **Brush your teeth and tongue** (including the back of your tongue) **without using toothpaste or mouthwash**. **Rinse** your mouth with water.

3. **Take the first collection tube and apply the label to the tube.** Be sure to **record the time and date of collection** to **the label** and **the collection time** on the **Breath Collection Table** (located on the requisition).



4. **Pick up** the mouthpiece/plastic bag in one hand and Tube 1 in your other hand.

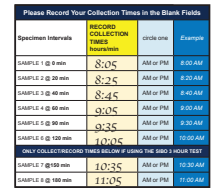
5. **Breathing normally, inhale and hold for 5 seconds.** Then close your mouth tightly around the mouthpiece and exhale normally into the plastic bag until it fills completely. **Do not blow hard.**

6. **Continue to exhale normally** with the bag expanded, and press the specimen tube into the side part of the mouthpiece. The needle will puncture the tube's self-sealing membrane allowing air to fill the tube. **Do not inhale at any point.**

7. **Remove the tube** within 2 seconds of puncturing. **You may stop exhaling** into the mouthpiece. **Do not unscrew** the cap on the collection tube. **Place** the tube in the bubblewrap bag.

8. **Immediately drink** the Lactulose solution before continuing with the rest of the breath test. **Drink** the entire amount within 5 minutes. **Do not drink water** for 1 hour after you drink the solution.

9. **Repeat** steps 3-7 for each breath collection, using the remaining tubes and labels 2-6, in order and according to the collection schedule. **Record** times on Collection Schedule found on the Test Requisition. (see image) ⟶



STOP HERE IF USING THE 2 HOUR COLLECTION!

Discard the remaining tubes.

CONTINUE TO STEP 10 IF USING THE 3 HOUR COLLECTION

10. **Repeat** steps 3-7 for each breath collection, using the remaining tubes and labels 7-8 in order and according to the collection schedule.

CHECKLIST (PRIOR TO SHIPPING)

1. All Tubes

- ❑ **Label** tubes you've been instructed to collect by your clinician
- ❑ **Label tubes with patient's first and last name, date/time of collection, and the tube number** – (**6 tubes for 2 hour collection – discard** the additional tubes) or (**8 tubes for the 3 hour collection**)
  - ❑ All tubes placed in **Bubblewrap bags**

2. Test Requisition Form with Payment

- ❑ Test Requisition Form is complete **Test is marked, patient's first and last name, date of birth, gender,** and **date of collection** are recorded
- ❑ **Collection table** on requisition has filled out with collection times
- ❑ **Payment** is included or pay online at **www.gdx.net/prc**
- ❑ **Complete** survey online at **www.gdx.net/prc**

3. Return to the Laboratory

- ❑ Be sure to return the specimen within the original package and place that inside the included mailing material(s)

SHIP THE SPECIMEN(S) TO THE LAB

Specimen(s) must be returned in the Genova Diagnostics specimen collection pack.
Please refer to the shipping instruction insert found in your specimen collection pack.

GENOVA DIAGNOSTICS

Call 800.522.4762 or visit our website at www.gdx.net

PATIENT BREATH COLLECTION INSTRUCTIONS

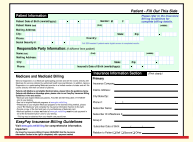
Small Intestinal Bacterial Overgrowth (SIBO)
GASTROINTESTINAL

The following test(s) can be collected using these instructions:

Small Intestinal Bacterial Overgrowth (SIBO) 2 hour #2306
Small Intestinal Bacterial Overgrowth (SIBO) 3 hour #2337

Test may not be processed without this information.

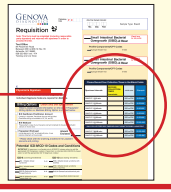
Test Requisition Form



Please Label:
- ❑ Patient's first/last name
- ❑ Date of Birth
- ❑ Gender
- ❑ Date of Collection

All Tubes

Please Label:
- ❑ Patient's first/last name
- ❑ Date/time of Collection
- ❑ Tube number



VERY IMPORTANT
PATIENT MUST FILL IN COLLECTION TIMES ON THE TABLE LOCATED ON THE FRONT OF THE REQUISITION. PLEASE LOCATE AND HAVE DOCUMENT AVAILABLE DURING COLLECTION!

Specimen

- **Breath**

Additional Materials

- Labels
- 2 Bubblewrap Bags
- Test Requisition Form
- Mailing Envelope

Collection Materials

Vacuum-sealed Tubes
(6 for 2 hour collection) or
(8 for 3 hour collection)*

Mouthpiece/
Plastic Bag**

Lactulose
Solution
(10gm)

* The white rubber seal will often be either convex or concave. Either is okay.
** There is an intentional small hole in the plastic bag to keep from overinflating.

This test is not appropriate for children under 25 pounds.

Watch the collection video at www.gdx.net/tests/prep