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

Just In Health
Wellness Clinic

Spectracell Blood Test Cash Instructions:

1. Your test kit should arrive at your house within a week. You will also receive a pre-paid envelope to ship the test back to the lab, if you are shipping within the US.

2. The requisition form needs to be filled out carefully. It must be sent with the test, or your sample may be destroyed. The requisition form is on the following page to fill out, print and send in with the kit.

3. The full cash price form is attached below.

4. If you are unsure of your method, please see the invoice your test was on.

5. How to find a blood draw site:

   Go to www.spectracell.com, go to "clinicians", then go to, “find a draw site", & search by using your zip code.

Any other questions, please call the Spectracell lab at 800-227-5227

SpectraCell Laboratories

Science + Health + Solutions

Tel (713) 621-3101 Toll-Free (800) 227-LABS (5227) Fax (713) 621-3234 CLIA 45D0710715

REQUISITION NUMBER:

JUST IN HEALTH WELLNESS CLINIC

Justin Marchegiani, DC 251690

Physician Signature: Vendor ID:

FOR SPECTRACELL USE ONLY

Date Received | Batch Number

1 Patient Information - Use blue or black ink ONLY Fasting: Yes ☐ No ☐

REQUIRED - PLEASE PRINT

Date of Specimen Collection	Time Specimen Collected	Physician Name	Physician Telephone Number	NPI
		Dr. Marchegiani	512-535-1817	1477828408

Patient Name As Appears On Card (Last)	(First)	(Middle)	Social Security Number	Date of Birth (MM/DD/YY)	Gender

Patient Phone Number	Patient Street Address	City	State/Province	Zip Code	Country

2 ICD-9 CODES - REQUIRED

ICD-9 Code	ICD-9 Code	ICD-9 Code	ICD-9 Code
N/A			

3 PATIENT INSURANCE AUTHORIZATION

I hereby authorize the release of medical information related to the service described herein to any third party carrier, and assign payment directly to SpectraCell Laboratories, Inc.

Signature N/A Date

4 METHOD OF PAYMENT

SpectraCell Accepts Assignment of Medicare and Private Insurance

Attach copy of front and back of insurance and/or Medicare card, driver's license and ABN (when applicable)

SELECT PAYMENT METHOD(S)

- [ ] **INSURANCE - PREFERRED PAY (Prepayment Required)**
  - [ ] Paid by Patient [ ] Paid by Physician
- [ ] **MEDICARE (Prepayment Required if A& B Panel Ordered)**
- [X] **PHYSICIAN / PRACTITIONER**
  - [ ] Billed Monthly [X] Credit Card On File
- [ ] **CASH/UNINSURED PRICE (Full Payment Required)**

5 TYPE OF PAYMENT

[ ] Cash/Check #

[ ] Credit card (complete section 6)

GRAND TOTAL $ 0

6 CREDIT CARD INFORMATION (AMEX, MC, VISA, DISCOVER)

Credit Card Number N/A

Cardholder Name On Card

Exp Date: Security Code:

LEGEND - MEDICARE TEST SELECTION

♦ Limited Frequency & ABN Required ● Medicare Limited Coverage-Include DX codes & ABN Required ★ Statutorily not covered by Medicare-Paid by Patient

■ Cannot be ordered for Medicare patients **Tests Covered by Medicare MUST be selected individually and NOT as a panel.**

7 [X] Micronutrient Panel

- [ ] Asparagine
- [ ] Calcium
- [ ] Chromium
- [ ] Copper
- [ ] Cysteine
- [ ] Glutamine
- [ ] Glutathione
- [ ] Magnesium
- [ ] Manganese
- [ ] Oleic Acid
- [ ] Serine
- [ ] Vitamin A
- [ ] Vitamin B1
- [ ] Vitamin B2
- [ ] Vitamin C
- [ ] Vitamin E
- [ ] Vitamin K2
- [ ] Zinc

Limited Coverage Tests●

- [ ] Carnitine 277.81, 277.83, 277.84, 285.21 ICD-9
- [ ] Folate 331.0, 780.93, 780.99, 781.3 ICD-9
- [ ] Vitamin B6 266.1, 285.0, 333.99, 356.9 ICD-9
- [ ] Vitamin B12 266.2, 281.9, 356.4, 780.93 ICD-9
- [ ] Vitamin D3 268.2, 268.9, 733.00, 733.09 ICD-9

[ ] Antioxidant & B Panel ★

SPECTROX™ | IMMUNIDEX ® | Coenzyme Q10 | Lipoic Acid | Selenium | Biotin | Inositol | Pantothenate | Vitamin B3 | Choline | Fructose Sensitivity | Glucose/Insulin Metabolism

[ ] CardioMetabolic Panel

- [ ] Lipoprotein Fractionation
- [ ] Lipoprotein Particle Numbers
- [ ] Total Cholesterol ♦
- [ ] HDL Cholesterol ♦
- [ ] LDL Cholesterol ♦
- [ ] Triglycerides ♦
- [ ] Lipoprotein (a)
- [ ] Apolipoprotein B
- [ ] CRP hs
- [ ] Homocysteine● 266.2, 579.0, ____
- [ ] Insulin
- [ ] Glucose
- [ ] Hemoglobin A1c
- [ ] C-peptide
- [ ] Adiponectin

[ ] Pre-Diabetes Panel

- [ ] Insulin
- [ ] Glucose
- [ ] Hemoglobin A1c
- [ ] C-peptide
- [ ] Triglycerides ♦
- [ ] HDL Cholesterol ♦
- [ ] Adiponectin

For Adiponectin height: ____ ft. ____ in. wt. ____ lbs.

[ ] LPP Plus Panel

- [ ] Lipoprotein Fractionation
- [ ] Lipoprotein Particle Numbers
- [ ] Total Cholesterol ♦
- [ ] HDL Cholesterol ♦
- [ ] LDL Cholesterol ♦
- [ ] Triglycerides ♦
- [ ] Apolipoprotein B
- [ ] Lipoprotein (a)
- [ ] CRP hs
- [ ] Insulin
- [ ] Homocysteine● 266.2, 579.0, ____

[ ] LPP Basic Panel

- [ ] Lipoprotein Fractionation
- [ ] Lipoprotein Particle Numbers
- [ ] Total Cholesterol ♦
- [ ] HDL Cholesterol ♦
- [ ] LDL Cholesterol ♦
- [ ] Triglycerides ♦
- [ ] Lipoprotein (a)

[ ] Female Hormone Panel

- [ ] Androstenedione
- [ ] DHEA-S
- [ ] Estrone (E1)
- [ ] Estradiol (E2)
- [ ] Estriol, unconjugated (E3)
- [ ] FSH
- [ ] IGF-1
- [ ] LH
- [ ] Progesterone
- [ ] Prolactin
- [ ] SHBG
- [ ] Testosterone, Total
- [ ] Testosterone, Free (calc)

[ ] Male Hormone Panel

- [ ] Androstenedione
- [ ] DHEA-S
- [ ] Estrone (E1)
- [ ] Estradiol (E2)
- [ ] FSH
- [ ] IGF-1
- [ ] LH
- [ ] PSA Total
- [ ] SHBG
- [ ] Testosterone, Total
- [ ] Testosterone, Free (calc)

For Hormone Testing 1st day of last period ____; Post menopausal [ ] treated [ ] untreated ; [ ] Oral contraceptives

[ ] Thyroid Comprehensive

- [ ] T3 Free (FT3)
- [ ] T4 Free (FT4)
- [ ] T4 Total
- [ ] TSH
- [ ] Anti-Thyroglobulin Ab
- [ ] Anti-TPO Ab
- [ ] Thyroglobulin
- [ ] Thyroxine-Binding Globulin (TBG)

[ ] Thyroid Plus Adrenal

- [ ] T3 Free (FT3)
- [ ] T4 Free (FT4)
- [ ] T4 Total
- [ ] TSH
- [ ] Anti-Thyroglobulin Ab
- [ ] Anti-TPO Ab
- [ ] Thyroglobulin
- [ ] Thyroxine-Binding Globulin (TBG)
- [ ] Cortisol (time_____)
- [ ] DHEA-S

Genetic Tests

- [ ] Telomere★

Genotyping

- [ ] Apolipoprotein E●
- [ ] Factor V Leiden●
- [ ] Prothrombin G20210A●
- [ ] MTHFR●

Other

- [ ] Micronutrient/MTHFR Combo ■
- [ ] Add-on: Reverse T3

Other Available Panels

Standard Lipid	Thyroid Basic	Telomere/IGF1
Apolipoprotein A1	T3 Free (FT3)	Telomere ★
Apolipoprotein B	T4 Free (FT4)	IGF-1
Total Cholesterol ♦	T4 Total	
HDL Cholesterol ♦	TSH	
LDL Cholesterol ♦		
Triglycerides ♦		

Medicare coverage of vitamin tests is subject to a Local Coverage Determination. Medicare pays for covered laboratory tests that are reasonable and necessary for the diagnosis or treatment of an illness. Medicare requires that tests for vitamin deficiencies must be targeted at a specific suspected deficiency, and not ordered for general screening. Pursuant to the LCD, the Antioxidant and B Vitamin Panel is statutorily non-covered - **patient payment is required for this panel.** See SpectraCell's Medicare Coverage Updates and Medicare Patient Payment Options for details.

FOR THE MEDICARE LIMITED COVERAGE TESTS (subject to LCD), THE FOLLOWING ICD-9 CODES WILL BE CONSIDERED FOR REIMBURSEMENT.

VITAMIN B12 (CPT 82607), FOLATE (CPT 82746), HOMOCYSTEINE (CPT 83090)

261	Nutritional marasmus
262	Other severe protein-calorie malnutrition
263.0	Malnutrition of moderate degree
263.8-263.9	Other protein-calorie malnutrition
266.2	Other B complex deficiencies
281	Pernicious anemia
281.1	Other vitamin B12 deficiency anemia
281.2	Folate-deficiency anemia
281.3	Other specified megaloblastic anemias not elsewhere classified
281.9	Unspecified deficiency anemia
287.5	Thrombocytopenia, unspecified
290.0	Senile dementia, uncomplicated
331.0	Alzheimer's disease
333.99	Other and unspecified extrapyramidal diseases and abnormal movement disorders
356.4	Idiopathic progressive polyneuropathy
356.9	Hereditary and idiopathic peripheral neuropathy (unspecified)
529.0	Glossitis
536.0	Achlorhydria
555.0-555.2	Regional enteritis
555.9	Regional enteritis, unspecified site
579.0-579.4	Intestinal malabsorption
579.8	Other specified intestinal malabsorption
579.9	Intestinal malabsorption, unspecified
780.93	Memory loss
780.99*	Other general symptoms (* Note: Use to identify altered mental status)
781.2	Abnormality of gait
781.3	Lack of coordination
782.0	Disturbance of skin sensation
V12.1	Personal history of nutrition deficiency
V45.1	Renal dialysis status
V45.3	Intestinal bypass or anastomosis status
V58.11	Encounter for antineoplastic chemotherapy
V58.69	Long term (current) use of other medications

VITAMIN B6 (CPT 84207)

266.1	Vitamin B6 deficiency
285.0	Sideroblastic anemia
333.99	Other and unspecified extrapyramidal diseases and abnormal movement disorders
356.9	Hereditary and idiopathic peripheral neuropathy (unspecified)
529.0	Glossitis

CARNITINE (CPT 82379)

277.81-277.84	Carnitine deficiency
285.21	Anemia in chronic kidney disease
458.21	Hypotension of hemodialysis

VITAMIN D (CPT 82652)

252.0-252.02	Disorders of parathyroid gland
252.08	Other hyperparathyroidism
252.1	Hypoparathyroidism
268.0	Rickets, active
268.2	Osteomalacia, unspecified
268.9	Unspecified vitamin D deficiency
275.3	Disorders of phosphorus metabolism
275.41-275.42	Disorders of calcium metabolism
585.3-585.6	Chronic kidney disease (CKD)
588.81	Secondary hyperparathyroidism (renal origin)
733.00-733.03	Osteoporosis
733.09	Other osteoporosis
733.90	Disorder of bone and cartilage, unspecified

Specimen Collection and Processing - DO NOT COLLECT OR SHIP ANY SAMPLES ON SATURDAY OR SUNDAY

NUTRITIONAL TESTS: NO FASTING REQUIRED. Whole blood is required. Collect two blue black CPT tubes of whole blood. Invert tubes 5-6 times. Label with the patient name and date. DO NOT REFRIGERATE, FREEZE OR CENTRIFUGE. Ship in the nutritional test kit provided.

LPP™ TESTS: FASTING REQUIRED. Fasting 9 to 12 hours prior to the blood collection is required. Collect 2 ml of serum. Draw blood in the SST tube and allow to clot for 30 minutes. Centrifuge within one hour of collection for 15 minutes. Transfer the serum from the SST into the transfer vial provided. Label with the patient name, date and the word "SERUM". Keep refrigerated until shipped. Ship with the frozen ice brick in the refrigerated kit provided.

TELOMERE TEST: NO FASTING REQUIRED. Whole blood is required. Collect one blue top (sodium citrate) tube. Label with patient name and date. DO NOT CENTRIFUGE OR FREEZE. Ship in the nutritional test kit or refrigerated kit provided.

ALL GENETICS (EXCLUDING TELOMERE): NO FASTING REQUIRED. Whole blood is required. Collect one purple top (EDTA) tube. Label with patient name and date. DO NOT CENTRIFUGE OR FREEZE. Ship in the refrigerated or the nutritional test kit provided. All tests can be collected in the same purple top tube.

HORMONE AND THYROID TESTS: NO FASTING REQUIRED. Collect 2 ml of serum. Draw blood in the SST tube and allow to clot for 30 minutes. Centrifuge within one hour of collection for 15 minutes. Transfer the serum from the SST into the transfer vial provided. Label with the patient name, date and the word "SERUM". Keep refrigerated until shipped. Ship with the frozen ice brick in the refrigerated kit provided.

CARDIOMETABOLIC AND PRE-DIABETES TESTS: FASTING REQUIRED. Fasting 9 to 12 hours prior to the blood collection is required. Collect one gray top (sodium fluoride) tube of whole blood, one SST, and one purple top (EDTA) tube of whole blood. Allow the SST to clot for 30 minutes. Centrifuge within one hour of collection for 15 minutes. Transfer the serum from the SST into the transfer vial provided. Label with the patient name, date and the word "SERUM". Keep refrigerated until shipped. Ship the transfer vial of serum, the gray top tube of whole blood, and the purple top of whole blood with the frozen ice brick in the refrigerated kit provided.

ALL serum tests can be sent in the same transfer tube.