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

Just In Health
Wellness Clinic

Genova Lab Test Instructions for the Comprehensive Organix Acid Test Cash*
(Each test ordered will arrive separately.)

What you should receive:

1. Pre-paid FedEx envelope to send the lab test back.
2. Instruction on how to conduct the test.
3. Sample collection container.

What you need to do to complete the Organix test:

1. Please make sure you are choosing the correct Organix requisition form. **Only cash pay patients are to choose this form.**
2. If your insurance is not eligible for discount pricing, the cash test is the correct test for you.
3. Please fill out the requisition form with all of the required information. Please fill out everything except credit card and insurance information.
4. Complete the **1 day blood / urine** test, freeze immediately per instructions, and send the specimen that evening, or next morning to the lab, using the pre-paid FedEx envelope.
5. Don't worry about having to restrict intake to three 8 oz. glasses or less for 24 hours **but do try to cut your water consumption down**, just enough for you to feel thirsty by the end of that day is adequate so that next morning, your urine is not over diluted that could essentially throw off a false negative on the test.
6. You may drop off, or have a FedEx pick up scheduled. It is best to ship your specimen within 24 hours of collection.

What you need to do next:

1. Dr Justin will go over your lab results with you as soon as they are in. We typically receive results within 2-3 weeks.
2. Make sure you have an appointment scheduled with the Dr Justin to review the results.
3. If you have questions, please feel free and reach out to the office.

NOTE: You MUST include your requisition form with your test kit or your sample will be destroyed, and you will pay more for this test.

The Personal Health Assessment Form is not required. You can skip this form.

For any other questions, please call Genova Lab 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*

697-534-57

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

K-GDX-29

X **Organix #3301** IIP 150 CP 299

Profile Components	CPT Codes	Other / MC
Creatinine	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
8-OHdG	82542	

Organix Profile is not currently available in New York State

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).

___ R53.81 Other Malaise
___ R53.83 Other Fatigue
___ F41.9 Anxiety Disorder, Unspecified
___ L30.9 Dermatitis, Unspecified
___ G47.9 Sleep Disorder, Unspecified
___ E61.9 Deficiency Of Nutrient Element, Unspecified
___ E63.9 Nutritional Deficiency, Unspecified
___ L27.2 Dermatitis Due To Ingested Food

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.

Clinical Findings/Clinical Impressions:

THIS SPACE FOR LAB USE ONLY

69753457

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

69753457IK-GDX-29

REV:1019

Organix™ (Organic Acids) Profile

Specimen Collection Instructions

This specimen collection kit can be used for the following test(s):

0091 Organix℠ Comprehensive - Urine

0291 Organix℠ Basic - Urine

0097 Organix℠ Dysbiosis - Urine

0087 DNA/Oxidative Stress Marker (8-OHdG) - Urine

0088 Neopterin/Biopterin Profile - Urine

0391 Organix Comprehensive NY - Urine

0397 Organix Compounds of Microbial Origin NY - Urine

3291 Organix Basic NY - Urine

IMPORTANT:

All patient specimens require two unique identifiers (***patient's name and date of birth***), as well as ***date of collection***. **Patient's first and last name, date of birth, gender,** and **date of collection** must be recorded on the **Test Requisition Form** as well as all tube(s) and/or vial(s), using a permanent marker, or the test may not be processed.

Specimen

Overnight Urine, 12 ml, frozen

Collection Materials

- Clean collection container (NOT included in this kit)
- Clear-cap plastic vial with thymol preservative
- Disposable pipette

Shipping Materials

- Absorbent pad
- Ice pack
- Test Requisition Form
- Personal Health Assessment Form
- Biohazard bag with side pocket
- Specimen collection kit box
- FedEx® Clinical Lab Pak and Billable Stamp

GENOVA DIAGNOSTICS

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

 IS-MM-Organix-23820 rev 0414

Please read all instructions carefully before beginning.

Patient Preparation

- It is best to **ship your specimen within 24 hours of collection**. Please refer to the enclosed shipping instructions **before** you collect to determine what days you can ship your specimen.
- **It is not necessary** to discontinue nutritional supplements prior to this specimen collection. Abnormalities that may be found will reveal special needs that have not been met by recent dietary and supplemental intake.
- **Decrease** fluid intake to avoid excessive dilution of the urine
  - » For adults, **restrict** intake to three 8 oz. glasses or less for 24 hours
  - » **Make sure that no more than 8 oz**. of this is consumed after 8:00 PM the evening prior to urine collection
- **Do not collect** urine during menstruation
- Vial contains preservative - **Do Not Rinse**

Urine Collection

1. **Write** patient's **first and last name, date of birth**, **gender** and **date of collection** on the Test Requisition Form (located in the pouch on top of the Specimen Collection Kit Box), as well as on the clear-cap plastic vial, using a permanent marker.
   - **IMPORTANT**: To ensure accurate test results you must provide the requested information.
2. **Empty** bladder before going to bed at night. **Do not collect** this urine.
3. **Collect** urine (if any) during the night and first morning urine into a clean container.
4. **Pipette** urine, using a fresh disposable pipette, into the clear-cap plastic vial to the 12 ml mark **(DO NOT OVERFILL)**. **Screw** the cap on tightly.
5. **Dispose** of remaining urine.
6. **Freeze** the clear-cap plastic vial and ice pack.

Specimen Preparation

1. **Place** the frozen urine specimen, frozen ice pack, and absorbent pad into the biohazard bag.
2. **Staple** payment to the bottom right-hand corner of the completed Test Requisition Form and complete the Personal Health Assessment Form; **Fold** and **place** them in the side pocket of the biohazard bag.
3. **Seal** the biohazard bag, **place** it into the specimen collection kit box, and **close** the box.

Checklist (Prior to Shipping)

1. Vial

- ❑ Patient's first and last name, date of birth, gender, and date of collection are written on the vial
- ❑ Vial cap is screwed on tightly

2. Frozen

- ❑ Clear-cap plastic vial (urine)
- ❑ Ice pack

3. Test Requisition Form with Payment

- ❑ Test Requisition Form is complete
- ❑ Personal Health Assessment Form is complete
- ❑ Payment is included