IRON HORSE DIAGNOSTICS

ORDER ID
For IHDX internal use only

Requisition Form

PATIENT INFORMATION

First name | MI | Last Name

Date of birth (MM/DD/YYYY) | Sex M ◯ F ◯ | MRN (medical record number)

Ancestry: Asian ◯ Black/African American ◯ White/Caucasian ◯
Pacific Islander ◯ Hispanic ◯ Native American ◯ Mediterranean ◯
Other:

Email address (for report access after release by medical professional)

Phone

Address | City

State | ZIP code | Country

SPECIMEN INFORMATION

Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen.

Specimen type : EDTA PLASMA ◯ CSF ◯

Collection date (MM/DD/YYYY) *If not provided, date will be 1 day prior to our receipt of specimen.*

REASON FOR TESTING

Primary indication:

ICD-10 codes | **Previous results**

Notes:

ORGANIZATION INFORMATION

Organization name and address

Organization name

Phone | Fax

Address | City

State | ZIP code | Country

Primary clinical contact

Name | Role/title

Phone | NPI

Email address (for report access)

Ordering physician

◯ **Same as primary clinical contact**

Name | NPI

Email address (for report access)

Additional clinical or laboratory contact (optional)

Name | Email address (for report access)

Letter of Medical Necessity (LMN)

◯ I have attached an LMN and/or other documentation for insurance billing purposes.

◯ I agree to allow Iron Horse DX to transfer the information from this requisition to an LMN and/or other documentation using the ordering physician's name as the signature for insurance billing.

Family history of ALS? Yes ◯ No ◯

If yes, please describe in detail below.

Does the patient have other neurological conditions?

◯ Tramatic Brain Injury Date Diagnosed _____

◯ Stroke Date Diagnosed _____

◯ Other Date Diagnosed _____

◯ INSURANCE BILLING (U.S. ONLY)

◯ I have attached a copy of the patient's card

Insurance company name | Member ID#

Patient relation to policy holder: Self ◯ Child ◯ Spouse ◯ Other ◯

Policy holder name | Prior-authorization #

◯ INSTITUTIONAL BILLING

◯ Send invoice to organization address above

◯ PATIENT PAY BILLING

◯ Send invoice to address above

Billing First and Last Name | Phone

Credit Card # | EXP. Date | CVV

Billing address | City

State | ZIP code | Country

◯ OTHER BILLING

By signing this form, the medical profession acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo this testing and has been informed that Iron Horse may notify them of clinical updates related to these test results (in consultation with the ordering medical professionals indicated). The Patient has further been informed and hereby authorizes Iron Horse Diagnostics and its designees to release information concerning testing to their insurer in order to process and/or appeal claims on behalf of the Patient. For amounts received directly, the Patient agrees to remit payment to Iron Horse Diagnostics for testing services rendered. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable state law to order this test.

Medical professional signature | Date

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