Test Requisition Form

RSM Diagnostics Lab
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T: 302-592-4106 | F: 877-366-4706 | Email: info@rsmdiagnosticslab.com | Website: www.rsmdiagnosticslab.com

*** INDICATES REQUIRED FIELD**

1. WRITE PATIENT INFORMATION BELOW

*First Name: _____

*Last Name: _____

*Date of Birth: _____ *Sex: _____ *Phone: _____

*Email: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

2. WRITE PROVIDER INFORMATION BELOW

*Practice / Facility Name (write on line below):

_____

*Referring Provider (write one provider below):

Fmt: TITLE. FIRST & LAST, CREDS
E.g. Mr. John Doe, FNP | E.g. Dr. Maria Smith, MD

_____

COMPLETE SECTIONS NUMBERED 1 - 8

3. MAKE TEST SELECTION BELOW*

☐ Upper Respiratory Microscreen

☐ Total GI

☐ EGHA

Write other(s) or addon(s) below:

_____

_____

_____

4. WRITE ICD-10 DIAGNOSIS CODE(S) BELOW*

_____

_____

_____

5. FILL SPECIMEN INFORMATION BELOW

*Specimen Type (select one): ☐ Stool or ☐ Nasal & Throat Swab

*Collected By (name): _____

*Date and Time Collected: _____

6. INCLUDE PAYMENT INFORMATION ON BACK

Please flip this form over to complete the Payment Information section.

*I confirm that I have provided payment info on the back: ☐

7. REVIEW PROVIDER CERTIFICATION

By completing and submitting this test requisition and associated specimen, I certify that the ordered test(s) are medically necessary for the diagnosis or management of this patient, that required patient consent for specimen collection, testing, and release of results has been obtained, and that I am authorized under applicable law to order these test(s). I understand that RSM Diagnostics LLC will accession this requisition and specimen as a laboratory order in its KOLIMS system and will associate the order with my name and NPI, and that additional clinical documentation supporting this order and its medical necessity is maintained in the patient's medical record and will be available upon request.

*System-generated or **hand-written signature above,** or authenticated provider selection in KOLIMS, serves as the ordering provider's signature.*

8. READ AND SIGN PATIENT CONSENT & AUTHORIZATION

I acknowledge that my provider has explained the test(s) requested on this form and that I am voluntarily providing a specimen for analysis. I authorize release of my specimen and relevant medical information to RSM Diagnostics Lab. For insurance billing, I authorize payment of eligible benefits directly to RSM Diagnostics Lab. I understand these test(s) are out of network, may be denied as not medically necessary, experimental, or investigational, and that I am responsible for any unpaid balance, including the cash price listed on the back of this form. I understand that if all required fields marked with a red asterisk (*) and sections 1 through 8 are not fully completed, this TRF will be considered incomplete and may result in sample kit return and specimen denial, in which case testing will not be performed.

*PATIENT SIGNATURE: _____ *DATE: _____

Please flip this form over to complete the Payment Information section on the reverse side →

Flip the page over to find the Payment Information section on the backside of the TRF*

The ordering provider remains responsible for documenting the specific diagnosis, intent to order, and medical necessity in the patient's medical record and for supplying any ICD-10 code or supporting documentation required for billing or coverage. The referring provider selected or printed on this requisition is recorded in KOLIMS as the ordering provider for this test. By submitting this requisition and specimen, that provider is deemed to have authorized the order, and the authenticated provider selection or system-generated signature in KOLIMS may serve as evidence of that authorization. RSM Diagnostics LLC is not responsible for missing, incomplete, or unsupported diagnosis coding or medical necessity documentation supplied by the referring provider.

SELECT AND INCLUDE PAYMENT INFORMATION*

☐ **Credit or Debit Card (preferred option)**

Cardholder Name (exactly as it appears on the card): _____

Billing Address (must match the card billing statement): _____

Card Number: _____

Expiration Date: _____ CVV / Security Code: _____

☐ **Check (please attach or include with your return)**

Payable To: RSM Diagnostics Lab

Payment Options Available for Total GI and/or EGHA Only:

☐ **Medicare Available for Total GI or EGHA Only (no deposit required)**

Member Name (exactly as it appears on the card): _____

Medicare Member ID: _____

☐ **Commercial Insurance Available Only for Total GI or EGHA with Required $250 Deposit**

Please include your commercial insurance information below and submit the required $250 deposit separately. This deposit may be required at the time of test submission, excluding Medicare.

Type: _____ Insurance Company: _____

Member Name (exactly as it appears on the card): _____

Member ID: _____ Group Number (if listed on card): _____

Attach or include any required payment or insurance information for the option selected

Insurance & Payment Notice for Total GI and EGHA:

For Total GI and EGHA only, RSM Diagnostics may file a commercial insurance claim as a courtesy with completed insurance information and a required $250 deposit. We verify eligibility and benefits in advance. If insurance does not pay in full, the patient is responsible for the remaining balance.

For tests other than Total GI and EGHA, such as Upper Respiratory Microscreen, full payment is due at submission. To request reimbursement, obtain medical necessity documentation from your ordering provider and email **info@rsmdiagnosticslab.com** to request a superbill.

⚠ The ordering provider must supply appropriate ICD-10 diagnosis code(s). Missing, incomplete, or non-supportive code(s) may result in reduced insurance coverage or claim denial. ⚠

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RSM DIAGNOSTICS LAB

Important Information: RSM Diagnostics may submit claims to insurance as a courtesy, but insurance coverage is not guaranteed and benefits vary by plan. Patients are responsible for any deductibles, copayments, coinsurance, non-covered services, or any balance not paid by insurance. Medicare is billed in accordance with applicable regulations, and the patient is responsible for any non-covered charges, including services that may require an Advance Beneficiary Notice.

If all fields marked with a red asterisk (*) are not completed and sections 1 through 8 are incomplete, the TRF will be considered incomplete. Incomplete TRFs may result in return of the sample kit and specimen denial, in which case testing will not be performed.