Ayass bioscience™ LLC
Bridging Science and Precision Patient Care

LABORATORY Testing Requisition

1. PATIENT INFORMATION

Last Name | First Name | MI

Address

City | State | Zip

Phone | DOB (mm/dd/yyyy) | Gender ☐ Male ☐ Female

Email

2. PROVIDER INFORMATION

Clinic Name

Physician Name | NPI#

Address

City | State | Zip | Phone

Fax | Email

Ancestry ☐ Caucasian ☐ African American ☐ Ashkenazi Jewish ☐ Native American ☐ Central/South American ☐ Northern European ☐ Pacific Islander ☐ Western European ☐ Caribbean ☐ Eastern European ☐ Asian ☐ Hispanic ☐ Middle Eastern ☐ Other: _____

3. SPECIMEN COLLECTION

Specimen Type **Blood** | Date of Collection (mm/dd/yyyy) | Time of Collection (HH:MM) ☐ AM ☐ PM

Serum Separated from Cells Time (HH:MM) | Serum Frozen Time (HH:MM) | Plasma Separated from Cells Time (HH:MM) | Plasma Frozen Time (HH:MM)

4. BILLING INFORMATION

BILL: ☐ Insurance ☐ Medicaid ☐ Medicare ☐ Self Pay ☐ Worker's Comp ☐ Uninsured

Insurance | Subscriber ID | Group#

Worker's Comp Claim # | Date of Injury (mm/dd/yyyy)

Name of Policyholder | DOB (mm/dd/yyyy) | Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependant ☐ Other_____

5. LABORATORY ORDER FORM

ICD-10 DIAGNOSIS CODES: _____ _____ _____ _____ _____ _____

☐ Autoimmune Panel
- IgA-RF
- IgM-RF
- Anti-SM
- Anti-Scl-70
- Anti-dsDNA
- Anti-SS-A
- Anti-SS-B
- Anti-Jo-1
- Anti-RNP-70
- Anti-U1-RNP
- Anti-PR3
- Anti-MPO
- Anti-GBM
- Anti-CardioLipin-IgA
- Anti-CardioLipin-IgG
- Anti-CardioLipin-IgM
- C1q CIC
- Centromere
- Histone
- Ribosomal P
- CCP3.1
- Chromatin
- Beta-2 GlyP 1 Abx IgA
- Beta-2 GlyP 1 Abx IgM
- Beta-2 GlyP 1 Abx IgG
- LAC/DRVVT (Lupus AntiCoagulant)
- SCT (Silica Clotting Time)

☐ Coagulation Panel
- Fibrinogen Activity
- Protein C Activity
- Protein S Activity
- ATT III Activity
- APCR Screen F V
- Factor VIII Activity
- aPTT
- LAC/DRVVT (Lupus AntiCoagulant)
- SCT (Silica Clotting Time)
- PT
- Homocysteine
- D-Dimer
- Factor II
- Factor V
- Factor VII
- Factor IX
- Factor X
- Factor XI
- Factor XII
- Plasminogen
- Plasmin inhibitor

☐ Thyroid Panel
- FT3
- TT4
- TSH
- T-Uptake
- Tg (Thyroglobulin)
- Tg Ab II
- TPO- Ab

☐ Hematology Panel
- Folate
- Intrinsic Factor
- Vit B12
- EPO
- sTfR
- Ferritin
- CBC with Diff
- Iron Total
- Iron Saturation

☐ Chemistry Panel
- CMP
- LIPIDS

☐ Diabetes Panel
- HbA1c
- Insulin
- eAG (Estimated Average Glucose)

☐ Antiphospholipids Panel
- Beta-2 GlyP 1 Abx IgA
- Beta-2 GlyP 1 Abx IgG
- Beta-2 GlyP 1 Abx IgM
- Anti-CardioLipin-IgA
- Anti-CardioLipin-IgG
- Anti-CardioLipin-IgM
- LAC/DRVVT (Lupus AntiCoagulant)
- SCT (Silica Clotting Time)

☐ Allergy/Asthma Panel
- Total IgE
- Total IgA
- Total IgG
- Total IgM

☐ Inflammatory Bowel Panel
- Gliadin DP IgA
- Gliadin DP IgG
- Tissue TransGlutaminase (tTG) Antibodies IgA
- Tissue TransGlutaminase (tTG) Antibodies IgG

☐ Cardiovascular Panel
- HsC-Reactive Protein
- Apolipoprotein A1
- Apolipoprotein B
- D-Dimer
- BNP
- Troponin I (High Sensitivity)
- CK-MB
- Myoglobin
- Homocysteine
- Fibrinogen

☐ Special Chemistry Panel
- Uric Acid
- Magnesium
- Phosphorous
- LDH
- CK
- Lactate

☐ Inflammatory Liver Panel
- Mitochondria (M2) Antibody IgG

☐ Pulmonary Panel
- Alpha-1 Anti-Trypsin

☐ Endocrine Panel
- Cortisol
- DHEA-S
- Estradiol (High Sensitivity)
- FSH
- Inhibin A
- LH
- Progesterone
- Testosterone Free
- Testosterone Total
- Prolactin
- Vitamin D, 25 (OH)
- SHBG
- HGH (Human Growth Hormone)

☐ Pancreatic Panel
- Amylase
- Lipase

Additional Information:
☐ aPS/PT IgG
☐ aPS/PT IgM

☐ Renal Panel
- C3
- C4
- Kappa
- Lambda
- eGFR (Estimated Glomerular Filtration Rate)
- Creatinine
- BUN
- BUN/Creatinine Ratio

☐ Cancer Panel
- ☐ CA 125 (Ovarian)
- ☐ CA 15-3 (Breast)
- ☐ CA 19-9 (GI)
- ☐ CEA (Carcinoembryonic Ag)
- ☐ AFP (Alpha-fetoprotein)
- ☐ PSA, Total
- ☐ PSA, Free

6. PATIENT CONSENT

Billing ABN and Patient Plan Information: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing. This does not apply to specific site analyses. Insurance pre-qualification will not be performed for these tests, unless specifically requested. All tests ordered shall be processed and billed based on payor.
Patient Acknowledgment: I am covered by insurance and authorize Ayass BioScience, LLC to give my designated insurance carrier(s) plan on this form and other information provided by my health care provider necessary for reimbursement. I authorize Ayass BioScience, LLC to inform my Plan of my test results only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to Ayass BioScience, LLC. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded immediately to the laboratory.
Patient Consent: My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any other time.
Patient Consent for Research: ☐ By checking this box I DO NOT consent for the remaining part of my sample to be used for research purposes by Ayass BioScience, LLC.
Personal information will not be shared and will be kept confidential by Ayass BioScience, LLC.
If Signature is other than patient's. Printed Name_____

(mm/dd/yyyy)

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE | DATE

7. MEDICAL NECESSITY FOR TESTING

Mark test code for panel only if all tests listed are deemed medically necessary. Any test may be ordered individually. Panels include an interpretation. Please note, some tests are automatically reflexed based on abnormality of the original tests unless you indicate that you do not want it. These reflexed tests will incur an additional charge.
This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome, or disorder, and these results will be used in the medical management and treatment for this patient. Furthermore, recipients' information is true and correct to the best of my knowledge.

(mm/dd/yyyy)

HEALTH CARE PROVIDER'S SIGNATURE | DATE

TEST SUBMISSION CHECKLIST

- ☐ Copy of Patient Demographics
- ☐ Current Meds List
- ☐ ICD-10 Diagnosis Codes
- ☐ Patient's/Provider's Signatures
- ☐ Copy of Insurance Card (Front/Back)

Collected by: _____
Print Name
_____
Signature

LT-RF-V34

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