

1. PATIENT INFORMATION				2. PROVIDER INFORMATION			
Last Name		First Name		MI		Clinic Name	
Address				Physician Name		NPI#	
City		State	Zip	Address			
Phone		DOB (mm/dd/yy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	City	State	Zip	Phone
Email				Fax		Email	
Ancestry <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Native American <input type="checkbox"/> Central/South American <input type="checkbox"/> Northern European <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Western European <input type="checkbox"/> Caribbean <input type="checkbox"/> Eastern European <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other: _____							

3. SPECIMEN COLLECTION		
Specimen Type <input type="checkbox"/> Serum	<input type="checkbox"/> Serum Separated from Cells Time _____ <input type="checkbox"/> Serum Frozen Time _____	Date of Collection (mm/dd/yy) _____ Time of Collection (HH:MM) <input type="checkbox"/> AM <input type="checkbox"/> PM

4. BILLING INFORMATION			
BILL: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Self Pay <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Uninsured			
Insurance			
Name of Policyholder		DOB (mm/dd/yy)	Subscriber ID
Relationship to Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other _____		Worker's Comp Claim #	Date of Injury (mm/dd/yy)

5. CYTOKINE TESTING PANEL					
<input type="checkbox"/> Cytokines Panel	Growth Factors	Chemokines	Interleukins	Inflammatory Proteins	Additional Information:
Interferons	G-CSF	Eotaxin	Granzyme-B	PD-L1/B7-H1	
Viral Replication	GM-CSF	MIP-3b	IL-12p70	CD40L	
IFN-g	PDGF-AA	MCP-1	IL-10 IL-2	Tumor Necrosis Factors	
IFNα	PDGF-AB/BB	MIP-3a	IL-13 IL-3	TNF-beta	
IFN beta	TGfα	MIP-1a	IL-15 IL-33	TNFα	
Apoptosis	VEGF	MIP-1b	IL-17A IL-4		
Cytokine	FGF basic	GROα	IL-17E IL-5		
TRAIL	EGF	IP-10	IL-9 IL-6		
	Fit-3L	GROβ	IL-1b IL-7		
		IL-8	IL-1ra IL-1a		
		RANTES			

6. ICD-10 DIAGNOSTIC CODES REFERENCE	

7. PATIENT CONSENT	8. ORDERING PROFESSIONAL CONFIRMATION
<p>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.</p> <p>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.</p> <p>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.</p> <p>Patient Consent for Research: <input type="checkbox"/> 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.</p> <p>Personal information will not be shared and will be kept confidential by Ayass BioScience, LLC.</p> <p>If Signature is other than patient's. Printed Name _____</p> <p style="text-align: right;">(mm/dd/yyyy)</p>	<p>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.</p> <p>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.</p> <p style="text-align: right;">(mm/dd/yyyy)</p> <p style="text-align: center;">HEALTH CARE PROVIDER'S SIGNATURE _____ DATE _____</p>
TEST SUBMISSION CHECKLIST	
<input type="checkbox"/> Copy of Patient Demographics <input type="checkbox"/> Current Meds List <input type="checkbox"/> ICD-10 Diagnosis Codes <input type="checkbox"/> Patient's/Provider's Signatures <input type="checkbox"/> Copy of Insurance Card (Front/Back)	Collected by: _____ Print Name _____ Signature _____
PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____	