Test Requisition Form

Biotia

Clinician Information

Institution: _____
Name: _____
Address: _____
_____
Phone: _____
Email: _____
NPI Number: _____

Test Registration

Specimen Type: Urine
Test Type: BIOTIA-ID Urine NGS Assay
Collection Date: _____
Collection Time: _____
Collector Name: _____
Research Consent Obtained? (if applicable)
☐ Yes ☐ No

Patient Information

Email (optional): _____
MRN (optional): _____
First Name: _____
Middle Name (if applicable): _____
Last Name: _____
Date of Birth (mm/dd/yyyy): _____
Patient Phone Number: _____
Patient Street Address: _____
Patient City, State, Postal Code: _____

Sex: ☐ Female ☐ Male ☐ Prefer not to disclose

Race (optional):
☐ Asian
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ White

Ethnicity (optional):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Billing Information (if applicable)

Bill to:
☐ Patient
☐ Insurance
☐ Clinic

Insured relationship to patient:
☐ Self
☐ Children
☐ Spouse

ICD-10 Codes: _____
Policy Holder First Name: _____
Policy Holder Last Name: _____
Policy Holder Date of Birth: _____

Insurance Carrier Address: _____
Member Identifier: _____
Group Identifier: _____

I attest that I ordered this test as part of the patient's evaluation and care.

Place Specimen ID Sticker Here (if applicable)

_____ Order Date

_____ Clinician Signature