AMPRION®
Navigate Your Brain Health

Test Requisition Form

Please COMPLETE and SUBMIT this form with SPECIMEN.

Place Specimen Label Here

*** Required Fields**

Ordering Physician & Practice Information*

Physician Name		NPI		Phone			
Practice Name		Account #		Fax			
Address		City		State		Zip	

Patient Information*

Last Name*	
First Name*, Middle Initial	
Date of Birth* (MM/DD/YYYY)	
Gender	☐ Female ☐ Male
Patient ID / MRN	

Specimen Details*

Date Collected* (MM/DD/YYYY)	
Time Collected (HH:MM)	
Specimen Type*	☐ CSF (Lumbar) ☐ Other: _____
Comments	

Billing Information* - SELF-PAY ONLY. Insurance payment will be available at a later date.

Patient Billing Responsible party:
☐ Self
☐ Spouse
☐ Other _____

Name		Phone	
Address			
City, State, Zip			

Medicare Status* - We currently offer tests on a SELF-PAY basis only.

Is patient insured with MEDICARE? ☐ Yes ☐ No

If the patient is a MEDICARE beneficiary, a Medicare ABN (Advance Beneficiary Notice of Non-coverage) must be provided to the patient prior to ordering a test. A completed signed copy of the ABN **must** be included with this test requisition.

Diagnostic Test* - Order by checking box.

☐ SYNTap™ Biomarker Test - CSF

ICD-10* - Diagnosis Codes

(Please provide all applicable diagnosis codes)

Relevant Clinical Information:

Drug therapy:		Last dose:	
		Last dose:	
		Last dose:	
Other relevant clinical information:			

Authorized Healthcare Provider*: I certify the above ordered test(s) is/are medically necessary for the diagnosis and treatment of this patient.

Healthcare Provider's Name (Printed):	Signature (*Required*):	Date:

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