AMPRION®
Navigate Your Brain Health

Test Requisition Form

Please COMPLETE and SUBMIT this form with SPECIMEN.

*** 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:

Amprion Clinical Laboratory 10355 Science Center Drive, #240 San Diego, CA 92121
Office: 858-461-6338| Fax: 866-770-4905
Email: Customer.Service@AmprionMe.com

A. Notifier: (Physician)

B. Patient Name: **C. Identification Number:** (Medicare Number)

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. Lab test** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Lab test** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
(X) 84999 SYNTap™ Biomarker Test, CSF	Amprion is not currently a Medicare provider. Medicare will not pay for these services at this time.	$1,500.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Lab test** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **D.**____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D. Lab test** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.**____________ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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