



1400 Hand Avenue, Suite L.  
Ormond Beach FL 32174-5126  
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# Delayed Food Allergy Requisition

TEST REQUESTED :  44 Foods  88 Foods  132 Foods Additives, Dyes

Diagnostic-ICD9 Code: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Time / Date Collected \_\_\_\_\_

**PHYSICIAN INFORMATION :** This section must be completed by a physician.

Name: \_\_\_\_\_ Dr's UPIN# \_\_\_\_\_  
 Street: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Signature:(Mandatory) \_\_\_\_\_

**PATIENT INFORMATION :** Please print clearly or type all information or insurance can not be filed.

Name: \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Street: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Contact Phone #: \_\_\_\_\_ Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male

**INSTRUCTIONS:** Please include your patient symptom sheet, insurance information and a photocopy of your insurance card (front & back) and two of the physician's business cards. Sage will submit your claim to insurance for the full cost of the test. The Sage test is administered in three groups of 44 antigens totaling 132 items and billed to your insurance at the rate of \$21.00 per antigen using procedure code 86160.

**INSURANCE INFORMATION :** Please provide a copy (FRONT AND BACK) of the patient's insurance card and complete fully.

Ins. Company: \_\_\_\_\_ Subscriber's: \_\_\_\_\_  
 Street: \_\_\_\_\_ Employer: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**HIPPA Patient Consent:** I understand that under the Health Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to 1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payers. 3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**IMPORTANT:** Sage Medical Laboratory is a **MEDICARE PROVIDER**, however, we DO NOT ACCEPT MEDICAID. Sage Medical Laboratory may be out of network for all other insurance carriers. I understand that Sage files my insurance claim, as a courtesy, and I will be responsible for my deductible and co-payment as determined by the terms of my policy.

I hereby authorize the release of any medical or other information necessary for the processing of insurance claims. In addition, I authorize the payment of medical benefits from any insurance or government program to Sage Medical Laboratory for services provided. I agree that should this account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney fees, and court costs. A photocopy of this is as valid as the original. *If signature is not present below, then THE TEST WILL NOT BE RUN.*

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

LAB OFFICE USE ONLY:

Payment Type: \_\_\_\_\_ Amount Paid: \$ \_\_\_\_\_ Date Paid: \_\_\_\_\_ Fax to Proclaims Date: \_\_\_\_\_ By: \_\_\_\_\_

Lot Numbers: \_\_\_\_\_



## **INSTRUCTIONS**

Take the Food Allergy Requisitions form to your doctor and ask to have the **PHYSICIAN INFORMATION** section completed and signed by the physician. Also, please make a copy of the front and back of your insurance card accompanies the Food Allergy Requisition.

Please, make sure that all blanks are filled completely.

Please return the following:

- Specimen draw kit
- Patient Symptom Form
- Completed Patient Requisition Form

Use the prepaid FedEx package:

- Call FedEx to arrange a pick-up
- Call Sage (1-877-SAGELAB) with the tracking number

Thank you,  
Sage Medical Laboratory