Provider/Patient Use Only (please select one): ☐ New Sample ☐ Replacement Sample

Date Specimen Collected: _____ Initial Here: _____

Laboratory Use Only –

Date Specimen Received: _____ Specimen ID: _____

MitoSwab™

5110 Campus Drive, Suite #120 | Plymouth Meeting, PA 19462
T: 484-534-9311 | F: 484-842-3400 | E: support@mitoswab.com | https://mitoswab.com

SAMPLE INFORMATION [PROVIDER TO COMPLETE]

Specimen Type: MitoSwab™ Buccal Swab	Diagnosis Code(s): (required in case of insurance billing)
Provider Preferred Method for Reporting: ☐Email ☐Fax ☐Other:	

FACILITY INFORMATION [PROVIDER TO COMPLETE]

Physician Name:					
Facility Name:				Telephone:	Secure Fax:
Street:				Email:	
City:	State:	Zip:	Country:	NPI #:	

Physician acknowledgement: I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian about the test(s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test(s) to be performed. I confirm that the person listed as the ordering physician who has signed below is authorized by law to order the test(s) requested herein.

Physician Signature: **Title:** **Date:**

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (mm/dd/yyyy):	Gender: ☐Male ☐Female
Street Address:		Telephone:	
City:	State/Region:	Email:	
Zip/Postal Code:	Country:	Address & Contact details same for Responsible Party? ☐Yes ☐No	

PAYMENT INFORMATION – $350 (please select 1 of the 3 methods below; if requesting VOB, include insurance details as well)

☐ Credit Card Payment	Name on Card:	Billing Zip/Postal Code:	
	Credit Card #:	Expiration Date:	Security Code (CVV):
☐ Electronic Invoice Payment	Email for invoice delivery:		
☐ Check Enclosed (payable to Religen, Inc.)	Check Amount: $	Check #:	
Email for Billing Communications:			
☐ Insurance - optional (include copy of card)	Insurance Company Name:	Member ID #:	

PATIENT CONSENT & AUTHORIZATIONS

Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample, and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of MitoSwab™ to the ordering physician. I am aware that payment is required at the time of service and authorize Religen, Inc. to process the payment using the details above. I authorize Religen, Inc. and any third-party billing company contracted with Religen, Inc. to submit a claim for payment along with any required information for purposes of collecting payment from my insurance provider, if applicable. I understand if my insurance provider remits payment directly to me, I am to forward said payment directly to Religen, Inc. I understand that I am responsible for all charges **not covered** by my insurance provider, including any deductible, copayment or coinsurance as directed by my health insurance carrier(s).

Patient/Parent/Guardian Signature: **Date:**

Responsible Party Full Name (if other than patient): **Relationship to Patient:**

Powered By:

RELIGEN

COMPLETE, SIGN, AND RETURN ALL DOCUMENTS WITH THE SAMPLE