Affix Specimen Identification Label Here

MITOSWAB

5110 Campus Drive, Suite #120 | Plymouth Meeting, PA 19462
T: 484-534-9311 | E: info@mitoswab.com | http://mitoswab.com

FACILITY INFORMATION (PLEASE PRINT)

Physician Name:				Date Specimen Collected:	
Facility Name:				Telephone:	Secure Fax:
Street:				Email:	
City:	State:	ZIP:	Country:	NPI #:	
Diagnosis:				Diagnosis Code(s):	

Please indicate preferred method for receiving results: Email ☐ Fax ☐ Other ☐

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:_____

TEST : ☐ MITOSWAB ☐ MITOSWAB PLUS

PATIENT INFORMATION

Patient First Name:	Patient Last Name:			Responsible Party (if other than the patient):	
Date of Birth	Male: ☐	Female: ☐		Relationship to Patient:	
Street:				Street:	
City:	State:	Zip:		City: State: Zip:	
Telephone:				Email:	

PAYMENT INFORMATION

Bill to: ☐ Medical Insurance ☐ Medicare ☐ Medicaid ☐ Credit card ☐ Check enclosed made payable to Religen, Inc.

If billing medical insurance, Medicare or Medicaid, please include photocopy of front and back of card

Primary insurance name: _____ Insurance ID #: _____

Secondary insurance name: _____ Insurance ID #: _____

Charge: Amex ☐ Visa ☐ Mastercard ☐ Discover ☐

Credit Card Number: _____ Expiration Date: _____

Security Code (CVV): _____ Billing Zip Code: _____

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 authorize Religen, Inc. to submit a claim for payment along with any required information for purposes of collecting payment from my insurance provider including Medicare. 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 any and all charges not covered by my insurance provider, including any deductible,
copayment or coinsurance as directed by my health insurance carrier(s).

PATIENT SIGNATURE: _____ Date: _____

Patient acknowledgment: After testing is completed, your remaining sample may be used for research purposes, such as the development of testing procedures and/or standards.

PATIENT SIGNATURE: _____ Date: _____

POWERED BY: RELIGEN

CLIA ID #: 39D2130307