NAIL REQUISITION

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PLEASE ATTACH: COPY OF INSURANCE CARD (FRONT/BACK) AND DEMOGRAPHIC SHEET
Missing Information May Delay Turn-Around-Time and Reporting of Results.

1 PATIENT INFORMATION

Collection Date:

Facility name (if applicable)		Attach Facesheet of patient info
Patient Name (Last)	(First)	(Middle)
Date of Birth	Race	Ethnicity
Social Security Number		Gender
Address		
City	State Zip	Phone

3 INSURANCE INFORMATION

Clearly mark all mandatory billing sections

Is this patient a SKILLED (Medicare A) patient? ☐ YES ☐ NO

Primary Insurance	Policy #	Group#
Person Insured	Self/Spouse	DOB of Insured
Secondary Insurance	Policy #	Group#
Person Insured	Self/Spouse	DOB of Insured
Prior Authorization #		

2 PROVIDER INFORMATION

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

Are you a mobile provider ☐ YES ☐ NO If yes, fill out section #1 in its entirety.
Does patient live in ☐ Residential Home ☐ LTC

4 BILLING INFORMATION

Please bill my credit card: ☐ AMEX ☐ MasterCard ☐ Visa ☐ Discover

Name as it appears on card:		
Account #:		
Expiration Date:	CVC:	
Amount:		Date:

I have been notified of the test cost and understand that my credit card will be charged the full amount for the testing. Patient Signature Section, please add "Patient signature is required for patients with TRICARE insurance.

Patient/Guardian Signature:

TEST SELECTION CHECK APPLICABLE BOXES

Sample Type / Location:

ALLERGIES:

Renal FXN: ☐ NML ☐ ABNL Hepatic FXN: ☐ NML ☐ ABNL

MARKERS:
☐Pregnant ☐Warfarin ☐Recurrent UTIs ☐Immunocompromised ☐Renal compromised ☐Dialysis ☐Hepatic compromised ☐Catheter

☐ NAIL PANEL - ORGANISM TESTED WITH ABR

Check this box for testing entire panel

BACTERIUM
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Klebsiella pneumoniae
- ☐ Klebsiella oxytoca
- ☐ Enterococcus faecalis
- ☐ Enterococcus faecium
- ☐ Pseudomonas aeruginosa
- ☐ Staphylococcus aureus
- ☐ Streptococcus pyogenes

FUNGAL
- ☐ Epidermophyton flocossum
- ☐ Alternaria alternata
- ☐ Acremonium strictum
- ☐ Aspergillus terreus
- ☐ Trichophyton rubrum
- ☐ Fusarium solani
- ☐ Aspergillus niger
- ☐ Microsporum audouinii
- ☐ Trichophyton interdigitale
- ☐ Microsporum canis
- ☐ Neofusicoccum mangiferae
- ☐ Candida krusei
- ☐ Candida albicans
- ☐ Candida glabrata
- ☐ Candida tropicalis
- ☐ Candida lusitaniae
- ☐ Candida auris
- ☐ Candida parapsilosis

ANTIBIOTIC RESISTANCE GENES

These are automatically tested in Reflex ABX – only when positives are detected.

- Ampicillin Resistance (ampC)
- Beta-Lactam Resistance (blaSHV-5)
- Carbapenem Resistance (VIM, IMP-7, OXA-23, OXA-40, OXA-48, NDM, KPC, IMP-16, OXA-72, OXA-58, blaOXA-48)
- Erythromycin Resistance (ermB)
- Extended-Spectrum-Betalactamase Resistance (TEM, SHV, CTX-M Group 1, CTX-M Group 2, CTX-M Group 8, CTX-M Group 9, CTX-M Group 25
- Macrolide Resistance (ermA, ermB, ermC)
- Methicillin Resistance (mecA (MRSA))
- Quinolone Resistance (QnrA, QnrB)
- Tetracycline Resistance (tetM)
- Vancomycin Resistance (VanA1, VanA2, VanB)

☒ PHARM D GUIDANCE

PhD Pharmacist driven interpretation of your patient's specific infection and anibiotic resistance markers for effective antibiotic recommendations consistent with Antibiotic Stewarship.

MEDICAL NECESSITY MUST BE COMPLETED

ICDs Listed for Convenience Only - Please document applicable ICD-10 Codes.

- ☐ L60.1 Onycholysis
- ☐ L60.2 Onychogryphosis
- ☐ L60.3 Nail dystrophy
- ☐ L60.4 Beau's lines
- ☐ L60.5 Yellow nail syndrome
- ☐ L60.8 Other nail disorders
- ☐ L60.9 Nail disorder, unspecified
- ☐ B35.1 Tinea unguium
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Patient Consent

I am voluntarily seeking laboratory service and hereby consent to provide a sample as requested. I have the right to refuse testing, but I understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded to the laboratory immediately.

Patient Signature: **Date:**

Medical Provider Consent

This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek further counsel. The patient has voluntarily decided to have the test performed by Vero Diagnostic Lab. As the medical provider, I am responsible for documenting applicable ICD-10 diagnosis codes.

Medical Provider Signature: **Date:**

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Patient Name:_____

Patient D.O.B. _____