LIVERFASt™

Test Requisition Form

Account Information

Fax to: **1-321-256-6061**

Clinic Name _____ Clinic Street Address _____

Phone Number _____ City _____ State _____

Fax Number _____ Zip _____ Email _____

1. Patient Demographics (attach a copy of patient demographics or insurance card) **Patient Medical Record Number**

Last Name _____ First Name _____ D.O.B _____ Gender ☐ M ☐ F

Patient Street Address _____ City _____ State _____ Zip _____

Patient Phone Number _____ **Weight** _____ Lbs. **Height** _____ Ft. _____ Inches

Bill to ☐ Medicare ☐ Commercial ☐ Medicaid

Insurance Co _____ Insurance ID# _____ Group # _____

Insurance Address _____ City _____ State _____ Zip _____

2. Test Information

☐ **LIVERFASt 0166U**

3. Diagnosis Information

ICD-10 Codes (Please provide 2-3 ICD 10 codes relevant to the patient):

The following commonly used diagnosis codes are listed as a convenience only. Ordering physicians should use ICD-10 codes that best describe the reason for performing tests, whether or not that code is listed below.

☐	B18.0 Chronic viral hepatitis B with delta-agent	☐	K73.9 Chronic Hepatitis, unspecified
☐	B18.1 Chronic viral hepatitis B without delta-agent	☐	K74.00 Hepatic fibrosis
☐	B18.2 Chronic viral hepatitis C	☐	K74.1 Hepatic sclerosis
☐	B18.8 Other chronic viral hepatitis	☐	K74.2 Hepatic fibrosis with hepatic sclerosis
☐	E11.9 Type 2 diabetes mellitus without complications	☐	K74.3 Primary biliary cirrhosis
☐	E66.9 Obesity unspecified	☐	K74.4 Secondary biliary cirrhosis
☐	E78.5 Hyperlipidemia, unspecified	☐	K74.60 Other and unspecified cirrhosis of liver
☐	G47.30 Obstructive sleep apnoea	☐	K75.4 Autoimmune hepatitis
☐	I10 Essential (primary) hypertension	☐	K75.89 Other specified inflammatory liver disease
☐	K70.0 Alcoholic fatty liver	☐	K76.0 Fatty (change of) liver, not elsewhere classified
☐	K70.2 Alcoholic fibrosis and sclerosis of liver	☐	K76.9 Liver Disease, unspecified
☐	K73.0 Chronic persistent hepatitis, not elsewhere classified	☐	R94.5 Abnormal results of liver function studies
☐	K73.1 Chronic lobular hepatitis, not elsewhere classified		
☐	K73.2 Chronic active hepatitis, not elsewhere classified		

☐ _____ ☐ _____ ☐ _____

4. Phlebotomy Information

☐ In-office ☐ ALTN ☐ ARCpoint Labs ☐ CPL Location _____

☐ In-home Phlebotomy ☐ Others (please specify) _____

5. Specimen Information

Collection Date _____ Collection Time _____ Collected By _____

6. Clinical Information

Clinician Name _____ NPI Number _____ Fax Number _____

I am a licensed medical professional. I acknowledge that the test requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer.
Note: Tests not ordered by the physician who is treating the beneficiary are not reimbursable. Order codes are updated but CPT Codes are not impacted

Clinician's Signature _____ Date _____

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