Celiac Disease Diagnostic Testing Requisition Form

CeliacDx™
P. (210) 895-4350 - F. (210) 236-5248
support@celiacdx.com

PATIENT INFORMATION

Name: _____ (First / MI / Last)

Date of Birth: _____ (mm/dd/yyyy)

Sex (Male, Female):_____

Email: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip:_____

Phone: _____

Symptoms:
☐ Intestinal ☐ Extra-intestinal ☐ None

Family History:
☐ Positive ☐ Negative ☐ Unknown

Gluten Consumption > Six Weeks:
☐ Yes ☐ No

PATIENT INSURANCE INFORMATION

Check one:

PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARD.

☐ **HMO, PPO, Commercial Insurance**

Please fill out the fields below OR provide a copy of the front and back of insurance card.

Insurance:_____ Policy #:_____

Policy holder: ☐ Self ☐ Other:_____
Relationship to Patient (e.g., "Spouse," "Parent")

Name:_____
Policyholder Info (if Other)

Date of Birth:_____Sex (Male, Female):_____

☐ **Medicare / Medicaid**

Please fill out the fields below OR provide a copy of the front & back of insurance card.

Subscriber ID: _____

An insurance claim will be filed on behalf of the patient. Patients with private insurance will receive a bill for any open balance after claim adjudication. Patients with Medicare or Medicaid may be billed for copays, coinsurance, or deductibles as per payer guidelines.

PRESCRIBER INFORMATION

Kit Delivery Method: ☐ We request kit delivery directly to the patient address ☐ We request collection kit delivery to our clinic address

Prescriber or Clinic Account Name: _____

NPI: _____

DELIVER TEST RESULTS TO: _____
Enter Email

_____
Enter Fax Number

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____

LABORATORY TEST ORDERED

CeliacDxTesting

☐ **HLA-DQ2/DQ8**
CPT code: 2x 81382
HLA-DQ2/DQ8 genotyping by next generation sequencing (NGS).

☐ **Pathology Clinical Consult Request**
CPT code: 80505
Comprehensive review of celiac disease testing including interpretation of histology, serology, and genetics result with a thorough review of history, medical records, relevant laboratory, pathology, and clinical findings.

Please include copies of any previous antibody or biopsy test results.

TEST DESCRIPTION

Celiac disease genetic testing will be conducted by PacificDx Laboratory in Irvine CA. A board certified pathologist will interpret results.

ICD-10 DIAGNOSIS CODE (REQUIRED)

☐ **R90.0** (Celiac Disease)
☐ **R19.7** (Diarrhea unspecified)
☐ **K59.0** (Constipation)
☐ **R10.9** (Abdominal pain)
☐ **R14.0** (Bloating)
☐ **Other:** _____

PRESCRIBER SIGNATURE (REQUIRED)

As the ordering prescriber named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, and, if required by my institution, has given informed consent.

SIGN HERE_____ **DATE**_____
PRESCRIBER SIGNATURE

PacificDx
5 Mason, Suite 100, Irvine, CA 92618
Laboratory Director: Shelly Gunn, MD, PhD