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: info@mitoswab.com | https://mitoswab.com

FACILITY INFORMATION (PLEASE PRINT IN BLUE or BLACK INK)

Physician Name:					
Facility Name:				Telephone:	Secure Fax:
Street:				Email:	
City:	State:	Zip:	Country:	NPI #:	
Diagnosis Code(s):				Diagnosis:	
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 OPTION (PLEASE SELECT ONE): ☐ MITOSWAB™ ☐ MITOSWAB PLUS™

PATIENT INFORMATION (REQUIRED*)

*First Name:	*Last Name:	Responsible Party: (if other than the patient)
*Date of Birth (mm/dd/yyyy):	*Male: ☐ Female: ☐	Relationship to Patient:
*Street Address:		*City:
*State:	*Zip:	Country:
*Telephone:	*Email:	Address same for Patient & Responsible Party? ☐ Yes ☐ No

PAYMENT INFORMATION

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

*****If billing medical insurance or Medicaid; please include a photocopy of the front and back of your card*****

Primary Insurance Company: _____ Insurance ID #: _____

Charge to: ☐ Amex ☐ Mastercard ☐ Visa ☐ Discover. Enclosed Check Only*: Amount $_____ Check # _____

Name on Card: _____ Credit Card #: _____ Expiration Date: _____

Security Code (CVV): _____ Billing Zip Code: _____ Email for receipt: _____

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. 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 Signature: _____ **Date:** _____

Patient acknowledgement: 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:

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