EmeritusDX
Together, We Save Lives

12 SPECTRUM POINTE DRIVE, LAKE FOREST, CA 92630 (800-959-2846)

EPIDERMAL NERVE FIBER DENSITY REQUISITION

Lab Use Only

CLIENT INFORMATION *(Please check requesting physician)*

☐ GLOBAL ☐ SLIDE PROCESS ONLY (TC) ☐ INTERPRETATION ONLY (PC)

PATIENT INFORMATION *(Green highlighted sections are required information)*

Please attach patient face sheet and front and back of primary and secondary insurance card: ***PATIENT NAME REQUIRED*** ☐ ***See Attached***

Name (Last, First):_____

Date of Birth: ___/___/___ Sex: M F SS#_____

Address: _____

City: _____ State:____ Zip:_____

Home Phone #: _____ Work Phone #: _____

Medical Record #: _____

BILLING INFORMATION

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client

Insurance: _____ Policy #:_____ Group #: _____

Ins. Address: _____ City: _____ State: ____ Zip: _____

Policy Holder: _____ DOB: _____

Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client

Insurance: _____ Policy #:_____ Group #: _____

Ins. Address: _____ City: _____ State: ____ Zip: _____

DATE COLLECTED: / / **TIME COLLECTED:** / / REPEAT BIOPSY: ☐ **ZAMBONI'S EXP DATE:** / /

CLINICAL HISTORY: _____

Indication(s) for Testing: _____

PHYSICIAN NOTICE Physician is required to (1) submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity, or (2) explain and have the patient sign an ABN.

STANDARD BIOPSY LOCATIONS (DEPTH: MINIMUM 3MM)

Specimen	(L) Sides	(R) Sides	Site							
A	☐ Left	☐ Right	☐ Proximal Arm	☐ Distal Arm	☐ Proximal Thigh	☐ Distal Thigh	☐ Calf	☐ Ankle	☐ Foot	Other:
B	☐ Left	☐ Right	☐ Proximal Arm	☐ Distal Arm	☐ Proximal Thigh	☐ Distal Thigh	☐ Calf	☐ Ankle	☐ Foot	Other:
C	☐ Left	☐ Right	☐ Proximal Arm	☐ Distal Arm	☐ Proximal Thigh	☐ Distal Thigh	☐ Calf	☐ Ankle	☐ Foot	Other:
D	☐ Left	☐ Right	☐ Proximal Arm	☐ Distal Arm	☐ Proximal Thigh	☐ Distal Thigh	☐ Calf	☐ Ankle	☐ Foot	Other:

ICD-10 CODES *(Please check all that apply)*

PRIMARY CODES ☐ **M79.20** Neuralgia and neuritis, unspecified multiple sites ☐ **G60.3** Idiopathic progressive neuropathy

SECONDARY CODES

☐ **G56.00** Carpal Tunnel Syndrome
☐ **E13.40** Diabetic neuropathy
☐ **M79.7** Fibromyalgia
☐ **M54.2** Neck Pain-Cervicalgia
☐ **R52** Pain, unspecified
☐ **79.606** Pain in leg, unspecified
☐ **79.2** Secondary Neuralgias
☐ **M00-M99** Disease of the musculoskeletal system and connective tissue
☐ **I99.8** Other disorder of circulatory system
☐ **M48.02-06** Spinal Stenosis
☐ **G89.29** Chronic Pain
☐ **M96.1** Postlaminectomy syndrome
☐ **M54.5** Low Back Pain
☐ **I73.9** Peripheral vascular disease
☐ **R20.2** Paresthesia
☐ **M47** Spondylosis, Cervial & Lumbar
☐ **G56.20** Cubital Tunnel Syndrome
☐ **G90.5** Complex Regional Pain
☐ **M79.1** Myofascial pain syndromes
☐ **G90.09** Complex Regional Pain
☐ **GM54.1** Radiculopathy
☐ **G57.5** Tarsal Tunnel Syndrome
☐ **Other:** _____
☐ **M96** Intraoperative and postprocedural complications and disorders of msculoskeletal system, not elsewhere classified

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS:

I authorize EmeritusDX to perform the necessary testing and share relevant information with my insurance company for payment. I agree to promptly submit any payments made directly to me and authorize EmeritusDX to handle any appeals or claim reviews with my insurance.
I understand that I am responsible for payment if my insurance does not cover the services.

PATIENT SIGNATURE: _____ **Date:** / /

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

Physician/Authorized Signature _____ *Signature required on this order or in the patient's medical record* **Date** _____ / _____ / _____

Specimens should be stored between 2-8 °C and shipped same day with ice pack

NAME: _____ NAME: _____ NAME: _____ NAME: _____

DOB:_____ DOB:_____ DOB:_____ DOB:_____

LOCATION: **LOCATION:** **LOCATION:** **LOCATION:**

Please make a copy of this document for your records.