KarmaCare Dx™
A Division of KPC Biotech, Inc.

KPC Biotech Molecular Laboratory
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CLIA#: 05D2227042
Fax: (951) 765-4829
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CANDIDA AURIS TEST REQUISITION FORM

Patient Information

Patient Name: ______________________

Date of Birth: __ / __ / ____ (MM/DD/YYYY)

Gender: Male __ Female __

Social Security #: ______________________

Address: ______________________

City: ____________ State: ____ Zip: ________

Phone #: ______________________

Billing Information

(please include a copy of the front & back of the insurance card)

BILL:
Medicare __ Medi-Cal __ Insurance __

Policy Name Holder (if not patient)

____

Patient relationship to policy holder

Self: __ Spouse: __ Child: __ Other: ____

Policy holder Date of Birth: __ / __ / ____ (MM/DD/YYYY)

Social Security # ______________________

Insurance Company Name: ______________________

Billing Address: ______________________

City, State, Zip: ______________________

Insurance ID: ______________________

Employer/Company Name: ______________________

Group #: ______________________

Authorization (Patient Signature):

X ______________________

ABN: I request and authorize KPC Biotech Molecular Laboratory to perform the designated test(s) on the DNA sample provided by me. My signature above constitutes my acknowledgement that I have been informed of the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional. I also understand that reference/testing lab reserves the right to provide de-identified information of a statistical nature to accrediting agencies and reserves the right to use such anonymous information.

Assignment of Benefits: I hereby authorize the entity to bill my insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with it's collection. I hereby authorize the entity, or their designee, to appeal my health plan on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Specimen Information

Collection Date: ___ / ___ / ____ Time: ____________

Source: ______________________

Collector Initial: ______________________

ORDERING CLINICIAN / LABORATORY INFORMATION

Facility/Practice Name: ______________________

Office Contact Name: ______________________

Office Phone Number: ______________________

Ordering Physician: ______________________

NPI #: ______________________

Physician Signature:
X ______________________

My Signature, as attending physician, serves as authorization of this test as medically necessary.

ICD-10 CODES

SPECIMEN TYPES: Axilla, Groin, or Axilla & Groin Swab

ICD-10 Codes: ______________________

☐ **Candida Auris**

- ☐ Candida auris