NeuroPoint Dx
Point. Act. Thrive.
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NeuroPointDX Use Only

☐ Req.
☐ Sam. _____
☐ Pay. _____

NPDX ASD TEST REQUISITION FORM

PHYSICIAN

Healthcare Organization	**Phone**	**Secured Fax** (for Return of Test Results)
Address 1	**Address 2** (optional)	
City	**State**	**Zip**
Requesting Physician	**NPI #**	
Physician Signature	**Date** / /	

LAB

Laboratory (if Different from Above)	**Phone**	
Address 1	**Address 2** (optional)	
City	**State**	**Zip**

PATIENT

Last Name	**First Name**	**Middle Initial**
Patient ID/MRN	**Sex** ☐ Male ☐ Female	**Date of Birth** / /
Parent/Guardian Last Name	**Parent/Guardian First Name**	
Parent/Guardian Phone Number	**Parent/Guardian Email** (optional)	

TEST

Test Name *For NPDX Autism Testing, both tests are required.*
☐ **NPDX Amine Test** (PLA Code: 0063U)
☐ **NPDX Energy Test** (PLA Code: 0263U)

ICD-10 Code(s)
☐ F84.0 (Autism)
☐ E88.9 (Disorder of Metabolism)
☐ K92.9 (Gastrointestinal Disorder)
☐ G98.8 (Neurological Disorder)
☐ Other code(s) _____

SPECIMEN

Specimen Type *Blood Plasma*
Note: The patient must fast for 12 hours prior to blood draw.

Last Food Intake **Date** / / 20_____
Time : AM / PM (circle one)

Specimen Collection **Date** / / 20_____
Time : AM / PM (circle one)

INSURANCE

Insurance Company Name	**Phone**	**Fax**
Address 1	**Address 2** (optional)	
City	**State**	**Zip**
Medicare HIC # (if applicable)	**Medicaid #** (if applicable)	
Subscriber Name	**Patient Relationship**	
Subscriber #	**Group #**	

Patient Acknowledgement & Authorization: ☐ I acknowledge that I have provided accurate insurance information for direct insurance/3rd party billing. I hereby authorize my insurance benefits to be paid directly to Stemina Biomarker Discovery. I understand that I am responsible for any amounts not paid by my insurer. **Signature** _____ **Date** / /

PAYMENT

Self-Payment Method ☐ Credit Card ☐ Check* ☐ PayPal **Make checks payable to:* ***NeuroPointDX***	**Credit Card Type** ☐ Master Card ☐ Visa ☐ Discover	
Payment Amount	**Name on Credit Card**	
Credit Card Number	**Credit Card Expiration** /	**Security Code**
Signature for Credit Card Payment		