HEALTHTRACKRx
Fast, Accurate & Actionable

1500 Interstate 35W
Denton, TX 76207
Customer Service: 866-287-3218
Web: HealthTrackRx.com

INSTRUCTIONS FOR COMPLETING A HEALTHTRACKRX REQUISITION

If you have any questions, please contact your Account Representative, or call HealthTrackRx Client Experience at 866-287-3218.

Section 1

1 Facility Name *(required)*

Clearly print facility name, full address, ordering provider's name and credentials.

2 Diagnosis (ICD-10) Codes *(required)*

Provide all applicable ICD-10 codes to the highest degree of specificity.

3 Billing Information *(required)*

Mark insurance, self-pay or client bill (reference lab only). If marking insurance, attach a copy of the patient demographics (face sheet) and insurance provider information.

A Patient Information *(required)*

Clearly print the patient's legal first and last name, full patient address, date of birth and gender. Ensure date of collection and sample collector initials are provided.

HEALTHTRACKRx

AIT Laboratories
1500 Interstate 35 W
Denton, TX 76207
Customer Service: 866-287-3218
Fax: 940-295-1483
www.HealthTrackRx.com
CLIA# 45D2009077
Medical Director: John K. Granger, MD

1

Facility Name, Address, City, State, Zip Code
Facility Demo, LLC. (ID)
1500 I-35 W, Denton, TX 76207

Please PRINT the Ordering Provider information below. REQUIRED
First Name: **All**
Last Name: **Doctor** Credentials: **MD** (MD, DO, FNP, PAC, etc.)

A PATIENT INFORMATION - PLEASE PRINT LEGIBLY REQUIRED

First Name: **Jane** Last Name: **Doe** MI
Address*: **1234 Anywhere Lane**
Phone*: **123-456-7891** Date of Birth: **01/01/2000**
Gender: ☐ Male ☒ Female ☐ Other
Race*: Ethnicity*:
Sample Date of Collection: **5/7/2021** **Sample Collector Initials:** **EH**

**Address, Phone, Race and Ethnicity are required fields for all menus including COVID-19.*

IN ADDITION TO WRITING IN PATIENT INFORMATION, ATTACH A COPY OF THE PATIENT DEMOGRAPHICS

DIAGNOSIS (ICD-10) CODES REQUIRED

U07.1

2

BILLING INFORMATION REQUIRED

☒ Insurance
☐ Self-Pay
☐ Client Bill (Reference Lab Only)

ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT INSURANCE CARD

3

HEALTHTRACKRx
Fast, Accurate & Actionable

Section 2

B Infectious Disease Test Orders *(required)*

Select either primary menu or specific pathogens within the menu. Testing will be delayed if an order is not selected. Select sample type submitted for testing.

B INFECTIONS DISEASE TEST ORDERS *(Select either primary menu or pathogens within the menu)* — **SELECT ONE OR MORE (REQUIRED)**

SAMPLE TYPE: ☐ Vaginal Swab ☐ Penile Swab ☐ Urine Swab ☐ Other:

☐ SEXUALLY TRANSMITTED INFECTION**

- ☐ Atopobium vaginae
- ☐ Chlamydia trachomatis
- ☐ Gardnerella vaginalis
- ☐ Herpes simplex virus 1 & 2[7]
- ☐ High Risk HPV Types 16, 18, 26, 31, 33, 35, 39, 45, 51, 52, 53, 56, 58, 59, 66, 67, 68, 69, 70, 73, 82
- ☐ Mycoplasma genitalium, hominis
- ☐ Neisseria gonorrhoeae
- ☐ Trichomonas vaginalis
- ☐ Ureaplasma urealyticum, parvum
- ☐ **Antibiotic Resistance Genes** *(listed below)*

SAMPLE TYPE: ☒ Vaginal Swab ☐ Penile Swab ☐ Urine Swab ☒ Other:

☐ CHLAMYDIA, GONORRHEA & TRICHOMONAS**

- ☐ Chlamydia trachomatis
- ☐ Neisseria gonorrhoeae
- ☐ Trichomonas vaginalis

SAMPLE TYPE: ☐ Vaginal Swab ☐ Other:

☐ BACTERIAL VAGINOSIS**

- ☐ Atopobium vaginae
- ☐ Bacteroides fragilis
- ☐ BVAB 2, 3 (bacterial vaginosis associated bacteria 2, 3); Mobiluncus spp.
- ☐ Gardnerella vaginalis
- ☐ Megasphaera (type 1 and 2)
- ☐ Mycoplasma genitalium, hominis
- ☐ Ureaplasma urealyticum, parvum
- ☐ **Antibiotic Resistance Genes** *(listed below)*

SAMPLE TYPE: ☐ Vaginal Swab ☐ Other:

☐ AEROBIC VAGINITIS**

- ☐ Enterococcus faecalis, faecium
- ☐ Escherichia coli
- ☐ Staphylococcus aureus
- ☐ Streptococcus agalactiae[9]
- ☐ **Antibiotic Resistance Genes** *(listed below)*

Section 3

C Patient Acknowledgment *(required)*

A patient signature is required.

D Authorized Healthcare Provider Acknowledgment *(required)*

A healthcare provider signature is required.

C PATIENT ACKNOWLEDGMENT — **REQUIRED**

This specimen was provided voluntarily for analysis and I authorize AIT Laboratories, a HealthTrackRx company, to process, bill and provide results. I agree to the declarations and terms in the patient acknowledgment and irrevocable assignment of benefits on the back of this form.

Patient Signature: Jane Doe Date: 5/8/2021

D AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT — **REQUIRED**

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. I have certified medical necessity in Section C and/or I have provided the appropriate diagnosis codes (ICD-10) to support medical necessity on this form and understand the Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

Provider Signature: All Doctor, MD Date: 5/8/2021

866-287-3218 info@healthtrackrx.com www.HealthTrackRx.com