DermSTAT™

Diagnostics by bako dx

855-422-5628

6240 Shiloh Road
Alpharetta, GA 30005

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

SPCR1300000

Date collected: _____ /_____ /_____

Time collected: _____

15506 Rev082621

DermSTAT™ SKIN INFECTION PCR TEST REQUISITION FORM

PATIENT INFORMATION

Date of Birth: __ __ / __ __ / __ __ __ __ Phone #: __ __ __ - __ __ __ - __ __ __ __ Sex: ☐ Female ☐ Male

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt/Suite: _____ City: _____

State: __ __ Zip Code: _____ Medical Record # (optional): _____

SPECIMEN INFORMATION *(Specimen type: skin scraping only)*

Choose DermSTAT™ PCR Panels *(Currently unavailable in NY)*	**Site of Specimen Collection**	**ICD Codes** *(See back)*
☐ **Superficial Mycosis Panel** *(Skin scraping, submit DRY)* Tinea or Dermatophytosis, Pityriasis versicolor, Candidiasis		
☐ **Cutaneous Bacterial Panel** *(Skin scraping, submit DRY)* Impetigo, Folliculitis, Erysipelas		
☐ **Skin Virus Panel** *(Skin scraping, submit DRY)* Herpes Simplex Virus 1, Herpes Simplex Virus 2, Varicella Zoster Virus		
☐ **Web Space Panel** *(Skin scraping, submit DRY)* Tinea, erythrasma, Candidal intertrigo, bacterial infections		
☐ **Scabies Assay** *(Skin scraping, submit DRY)* **Plus Secondary / Co-infection** *(Skin scraping, submit DRY)* ☐ Cutaneous Bacterial Panel ☐ Superficial Mycosis Panel		

PHYSICIAN NOTICE: *When ordering tests, the physician is required to make an independent medical necessity decision with regard to each test the laboratory will bill. The physician also understands he or she is required to (1) submit ICD-10 diagnosis supported in the patient's medical record as documentation of the medical necessity or (2) explain and have the patient sign an ABN.*

Physician Signature: _____ Date of Procedure: __ __ / __ __ / __ __ __ __

The requested test(s) is/are medically indicated for patient management.

To ensure processing, affix completed label to specimen container.

A	B	C	D
SPCR1100000	SPCR1100000	SPCR1100000	SPCR1100000
Patient Name/Initials: _____	Patient Name/Initials: _____	Patient Name/Initials: _____	Patient Name/Initials: _____
DOB: Site:	DOB: Site:	DOB: Site:	DOB: Site:

SEND ADDITIONAL COPY OF REPORT TO

Physician's Name: _____ Fax #: __ __ __ - __ __ __ - __ __ __ __

PATIENT BILLING INFORMATION

I have read the billing guidelines (see reverse side) and I understand my responsibilities as described within.

Patient/Responsible Party Name: _____

Signature: _____ Today's Date: __ __ / __ __ / __ __ __ __

By signing, I understand that the tests requested on this form may be out-of-network for my insurance plan and/or may be deemed not medically necessary, experimental, and/or investigational by my insurance carrier and I authorize the services to be performed regardless. I have been informed and agree that I will be financially responsible for copays/deductibles or for the amount described below for services deemed out of network, not medically necessary, experimental, and/or investigational by my insurer.

Primary Medical Insurance

Insurance Provider: _____

Member ID: _____

Group #: _____

Insured Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Secondary Medical Insurance

Insurance Provider: _____

Member ID: _____

Group #: _____

Insured Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Choose one payment option (required):

Please refer to reverse side for detailed information on policies for pricing, billing, and payment options.

☐ **Self Pay** (Provide payment information to the right)

☐ **Bill Insurance / Medicare**
(Provide credit card payment information to the right)

☐ **Medicaid**
BakoDx is a Medicaid provider for all states EXCEPT: CT, FL, HI, MA, NV, RI, and UT. Your Medicaid provider will be billed for services.

☐ Pay with Credit Card: MasterCard VISA AMEX

Credit Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ __ __ CVV: _____

Cardholder Full Name: _____

Cardholder Signature: _____

☐ Pay with Check (Self Pay option only)

Check Amount: $_____

(Make checks payable to: BakoDx) *Staple check to this form*

For patient:

TEST PRICING, BILLING GUIDELINES, & PAYMENT OPTION DESCRIPTIONS

Self Pay

Your credit card will be charged only the amount listed in the table below for each test ordered, and considered paid in full.

You will receive a receipt to the address provided, which may be used for filing Flex125 programs, insurance, etc.

Bill Insurance / Medicare

Your insurance provider will be billed for the full amount due.

Your credit card will be charged per your insurance provider's instructions as described in the yellow highlighted area on the reverse side.

Incomplete or inaccurate insurance information will be billed as Self Pay and considered paid in full.

Bill Medicaid

BakoDx is a Medicaid provider for all states EXCEPT: CT, FL, HI, MA, NV, RI, and UT. If you are covered by Medicaid in the states listed above, your Medicaid provider will be billed for services.

DermSTAT™ SELF PAY PRICING	
Superficial Mycosis Panel	**$109**
Cutaneous Bacterial Panel	**$109**
Skin Virus Panel	**$109**
Web Space Panel	**$199**
Scabies Assay	**$49**
Plus Secondary / Co-infection	
Cutaneous Bacterial Panel *or* Superficial Mycosis Panel	**$149** (Total)
Cutaneous Bacterial Panel *and* Superficial Mycosis Panel	**$199** (Total)

For physician:

DermSTAT™ SKIN INFECTION PCR TEST REQUISITION FORM

PANEL DESCRIPTIONS				
Superficial Mycosis Panel*	**Cutaneous Bacterial Panel***	**Skin Virus Panel***	**Web Space Panel***	**Scabies Assay***
Pan-Dermatophytes	*Streptococcus pyogenes* (GAS)	Herpes Simplex Virus 1	Pan-Dermatophytes	*Sarcoptes scabiei*
Candida spp	*Staphylococcus aureus*	Herpes Simplex Virus 2	*Candida* spp	
Malassezia spp	*mecA* (methicillin resistance)	Varicella Zoster Virus	*Corynebacterium minutissimum*	
			Pan gram-negative bacteria	
			*Staphylococcus aureus***	

*Currently unavailable in NY
**If positive, reflex to *mecA* (methicillin resistance)

ICD-10 codes are provided for convenience and informational purposes only.
Ordering practitioners must determine the ICD-10 codes most appropriate for each patient.

ICD-10 CODE	
Superficial Mycosis Panel L81 Disorder of pigmentation L03 Cellulitis L98 Disorder of the skin and subcutaneous tissue R23 Skin changes L85 Epidermal thickening L30 Dermatitis L08 Local infection of the skin and subcutaneous tissue, unspecified	**Web Space Panel** L81 Disorder of pigmentation L03 Cellulitis L98 Disorder of the skin and subcutaneous tissue R23 Skin changes L85 Epidermal thickening L08 Local infection of the skin and subcutaneous tissue, unspecified L02 Cutaneous abscess
Cutaneous Bacterial Panel L03 Cellulitis L30 Dermatitis L08 Local infection of the skin and subcutaneous tissue, unspecified L98 Disorder of the skin and subcutaneous tissue R23 Skin changes	**Scabies Assay** L81 Disorder of pigmentation L03 Cellulitis L98 Disorder of the skin and subcutaneous tissue R23 Skin changes L85 Epidermal thickening L30 Dermatitis
Skin Virus Panel L03 Cellulitis L30 Dermatitis L08 Local infection of the skin and subcutaneous tissue, unspecified L98 Disorder of the skin and subcutaneous tissue R23 Skin changes	