DermSTAT™

Diagnostics by

StrataDx

800-325-PATH (7284)
1 Cranberry Hill, Suite 303
Lexington, MA 02421

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

SPCR1100000

15503 Rev012920

DermSTAT™ SKIN INFECTION DNA (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™ DNA (PCR) Panels	Site of Specimen Collection	Additional Clinical Information
☐ **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 Signature: _____ Date of Procedure: ___ ___ /___ ___ /___ ___ ___ ___

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

I certify that I have obtained the required authorization and assignment of benefits for the laboratory to bill when insurance billing has been requested below. Physician authorizes Strata Pathology Services, Inc. to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

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**
StrataDx is a Medicaid provider for: CO, CT, IL, KY, ME, MD, MA, NE, NH, NJ, NM, NC, PA, SC, and VT. 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: StrataDx) *Staple check to this form*

DermSTAT™ Diagnostics by StrataDx

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

StrataDx is a Medicaid provider for: CO, CT, IL, KY, ME, MD, MA, NE, NH, NJ, NM, NC, PA, SC, and VT. 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)

Please also refer to the Laboratory Test Billing Guidelines & Process you received from your physician.

For physician:

DermSTAT™ SKIN INFECTION DNA (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**	

*If positive, reflex to *mecA* (methicillin resistance)