o. n. diagnostics LLC
NPI: 1306313648
phone: (510) 204-0688
ondiagnostics.com

VirtuOst®
Order Requisition Form

O.N. Diagnostics
Attention: IDTF
1936 University Ave, Suite 280
Berkeley, CA 94704

Physician Information

Name (First, Last) ____________________

NPI # ____________________

Healthcare Facility ____________________

Address ____________________

City, State, Zip ____________________

Phone Number ____________________

Email(s) ____________________

VirtuOst Test Information

Type of Test (choose one): BCT BCT with VFA

Reason for Testing ____________________

ICD Diagnostic Code(s) ____________________

Other Info ____________________

If spinal fusion pre-op, planned UIV level ____________________

Should OND provide a professional medical interpretation?

YES *(California patients only)* **NO** *(Physician will arrange)*

CT Scan Information

Should OND retrieve the CT scan from the Radiology Facility?

YES *(Fill out the information below)* **NO** *(Physician will mail CT Scan to OND)*

Radiology Facility ____________________

Address ____________________

City, State, Zip ____________________

Phone Number ____________________

Type of CT Scan ____________________

Scan Date (mm/dd/yyyy) ____________________

Patient Information Male Female

Name (First, Last) ____________________

Patient ID / MRN ____________________

DoB (mm/dd/yyyy) ____________________

Address ____________________

City, State, Zip ____________________

Phone Number ____________________

Email ____________________

Payment & Insurance (check one option)

Bill Medicare (Part B) — Attach a copy of *both sides* of patient's Medicare (and any secondary) insurance card

Self-Pay — OND will bill the patient for all services rendered (OND will not file any reimbursement claim)

Patient Authorizations

Overall Consent: I request, consent, and authorize O.N. Diagnostics, LLC (OND) to perform the *VirtuOst* diagnostic test as ordered and determined medically necessary by the healthcare professionals involved in my care.

Assignment of Benefits & Financial Responsibility: I authorize OND to bill my insurance/health plan and furnish them with my *VirtuOst* order information, test results, or any other information requested for reimbursement. I assign all rights and benefits under my insurance plans to OND, who I authorize to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursement to be paid directly to OND in consideration for services performed. I understand I am responsible for any amount not paid by insurance, including any copays or deductibles and any amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider. If self-paying, I agree to pay OND for all services rendered.

Use and Disclosure of Protected Health Information (PHI): I authorize an electronic copy of my CT scan to be released to OND for performing the *VirtuOst* test as part of my medical care. I understand my CT scan may contain sensitive information.

Patient Rights: This authorization for PHI is valid for one year from my signature and may be revoked by my written request to the Radiology Facility or to OND. I have the right to receive a copy of this authorization. I understand California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law.

Signatures (required for Physician and Patient)

Physician ____________________

Date of Order (mm/dd/yyyy) ____________________

Physician Certification: I am a licensed healthcare provider authorized to order the *VirtuOst* test, which I consider to be medically necessary for this patient. I will maintain the privacy of the test results and related information as required by HIPAA. I authorize O.N. Diagnostics to coordinate with any of its co-providers and/or the patient to retrieve the CT scan, perform the test, and arrange for any relevant billing or reimbursement.

Patient * ____________________

Date (mm/dd/yyyy) ____________________

Patient Authorization: By signing this form, I agree to all authorizations above, which I have read and understand.

* If signed by patient's legal representative, describe relationship to patient:

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Fax the completed form to O.N. Diagnostics at (877) 554-0688 or mail it to the address shown above.

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