o.n. diagnostics LLC
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# VirtuOst® Order Requisition Form

O.N. Diagnostics IDTF
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***email:*** idtf@ondiagnostics.com

## Physician Information

Name (First, Last) _____

NPI # _____

Fax # for Results _____

Phone # _____

## *VirtuOst* Test Information & Medical Necessity

**• Type of Test:** **BCT** ☐ **BCT with VFA** ☐

**• Should OND provide a professional medical interpretation?**

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

**• Medical Necessity**

*Medicare coverage criteria for BCT,* ***check all applicable:***

☐ No bone test (DXA, BCT, QCT, ultrasound) in last 2 years;

and one or more of the following conditions:

☐ Estrogen-deficient woman at clinical risk for osteoporosis
☐ Individual with vertebral abnormalities
☐ Individual on or about to go on steroids for > 3 months
☐ Individual with hyperparathyroidism

The physician should: 1) choose one or more of the above conditions or another reason (below) for medical necessity; 2) provide corresponding ICD codes (below); and 3) document necessity in the patient's medical record. ***Patients in traditional Medicare ("Part B") who do not meet the Medicare criteria require a signed ABN.***

Reason for Testing _____

_____

ICD Diagnostic Code(s) _____

## CT Scan Information

Radiology Facility _____

Address _____

Type of CT Scan _____

Scan Date (mm/dd/yyyy) _____

## Patient Information Male ☐ Female ☐

Name (First, Last) _____

DoB (mm/dd/yyyy) _____

Address _____

City, State, Zip _____

Phone # _____

Email _____

## Payment & Insurance (check one option)

**OND only accepts insurance for *Traditional Medicare* ("Part B"):**

☐ **Bill Traditional Medicare** — Attach a copy of both sides of the patient's Medicare (and any secondary) insurance card.

☐ **I will Self-Pay** — OND will bill the patient for all services rendered and will not file a reimbursement claim. The patient can use the OND invoice to file a claim against private insurance, ***including Medicare Advantage ("Part C").***

## 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:

_____

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

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