REALTIME LABORATORIES INC.
Cutting edge. Breaking barriers.

Do you have questions about submitting your test kit, payment, or shipping? Please call 1-855-692-6767

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INTEGRATED LABEL
BACK LAMINATE

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Therapeutic Drug Monitoring Test Requisition

Check One

- ☐ Doctor Pay
- ☐ Patient Pay
- ☐ Medicare - Sign ABN on Page 3
- ☐ Tricare
- ☐ Insurance

Specimen Type

☐ Serum
Red Top Tube = RED

Patient

Patient's Name (Last, First, MI)	Sex	Date of Birth
	☐ Male ☐ Female	MO DAY YR

Collection Date		Date Frozen / Refrigerated	Date Sent
	☐ Frozen ☐ Refrigerated		

Patient's Phone	Patient Email

MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)
Medicare Patients Must Complete and Sign ABN on reverse side

I hereby authorize payment directly to RealTime Laboratories, Inc. for all testing. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurance.

Patient Signature: Date:

Physician

Physician's Name (Last, First)	Physician's Signature
	X_____

Test and Sample Type

☐ M1000 Mycophenolic Acid / Mycophenolic Acid Glucuronide
Red Top Tube = RED

CPT Codes

80180 Drug screen given mycophenolate
Mycophenolate (mycophenolic acid) level

ICD-10 Codes

Requisition Continues on Back ⟶

RealTime Lab Use Only

Received Date:_____/_____/_____ Time:_____:_____ am pm Carrier: ☐ UPS ☐ FedEx ☐ USPS ☐ Other:_____

RTL Personnel:_____ Requisition Complete? ☐ Yes ☐ No Payment: ☐ Credit Card ☐ Check ☐ Doctor

Notes: _____ ☐ Other:_____

4100 Fairway Dr., #600, Carrollton, TX 75010 • Phone: 972-492-0419 Fax: 972-243-7759 / 972-492-0729
Website: www.realtimelab.com • CLIA: 45D1051736 • Tax ID#: 45-0669342 • CAP # 7210193

Clinical Information

Exact date of dose DD / MM / YYYY | Time of today's dose HR : MIN | Dose (mg) | Date of Surgery DD / MM / YYYY

Type of Mycophenolate: ☐ Cellcept (mycophenolate mofetil) ☐ Myfortic (mycophenolate sodium)

Co-medications: ☐ Tacrolimus ☐ Cyclosporine A ☐ Sirolimus ☐ Everolimus ☐ Prednisone

Other prescription medications: _____

_____

_____

☐ Pharmacokinetic Analysis for Pre-Surgery/Change of Pharmaceutical Protocol

SAMPLE NO	TIME SAMPLE DUE	Time of Collection	COMMENTS
1. Pre-Dose			
Drug Dose Administered (Exact Time):			
2. 30 min			
3. 1 hr			
4. 2 hr			
5. 4 hr			
6. 8 hr			
7. 12 hrs			

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(A) Notifier: RealTime Laboratories, Inc. 4100 Fairway Ct, #600 Carrolton, TX 75010 972-492-0419

(B) Patient Name: **(C) Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't by for **(D)** Laboratory Test below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **(D)** Laboratory Test below.

(D) Laboratory Tests	☐ MYCO15 Panel E8400 $299 ☐ Ochratoxin A E8501 $250 ☐ Aflatoxin Group E8502 $250 ☐ Trichothecene Group E8503 $250 ☐ Gliotoxin Derivative Test E8510 $250 ☐ Zearalenone $250	☐ MYCO15 Panel E8400 Follow Up $174 ☐ Mold Panel, IgG P5115 $169 ☐ Mold Panel, IgE P5114 $169 ☐ Aspergillus Species / Target M8605 $320 ☐ Candida Species/ Target M8617 $480 Other: _____
(E) Reason Medicare May Not Pay:	Your referring provider may not provided a diagnosis that supports medical necessity according to Medicare Coverage Policies and the repeat laboratory testings may exceed frequency limitations set by Medicare	
(F) Estimated Cost		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any question that you may have after you finish reading.
- Choose an option below about whether to receive the laboratory tests listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the I **(D)** Laboratory Test listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **(D)** Laboratory Test listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **(D)** Laboratory Test listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	**(J) Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.