Affix VS Specimen Identification Label Here

FRAT™
Folate Receptor Antibody Test

ILIAD Neurosciences

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FACILITY INFORMATION (PLEASE PRINT)

Physician Name:				Date Specimen Collected:	
Facility Name:				Telephone:	Secure Fax:
Street:				Email:	
City:	State:	ZIP:	Country:	NPI #:	
Diagnosis:				Diagnosis Code(s):	

Please indicate preferred method for receiving results: Email ☐ Fax ☐ Other ☐

Physician acknowledgement: I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian about the test[s] to be performed, and the patient specified below and/or their legal guardian has given consent for the test[s] to be performed. I confirm that the person listed as the ordering physician who has signed below is authorized by law to order the test(s) requested herein.

Physician Signature:_____ Title:_____ Date:_____

PATIENT INFORMATION

Patient First Name:	Patient Last Name:		Responsible Party (if other than the patient):		
DOB:	Male: ☐	Female: ☐	Relationship to Patient:		
Street:			Street:		
City:	State:	Zip:	City:	State:	Zip:
Telephone:			Telephone:		

PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW.

PAYMENT INFORMATION

Bill to: ☐ Credit card ☐ Check enclosed made payable to Iliad Neurosciences, Inc.

Charge: ☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number:_____ **Expiration Date:** _____

Security Code (CVV):_____ **Billing Zip Code:** _____

PATIENT CONSENT & AUTHORIZATIONS

Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Iliad Neurosciences, Inc. and for Iliad Neurosciences, Inc. to release the results of FRAT to the ordering physician. I authorize Iliad Neurosciences, Inc. to submit a claim for payment along with any required information for purposes of collecting payment from my insurance provider including Medicare. I understand if my insurance provider remits payment directly to me, I am to forward said payment directly to Iliad Neurosciences, Inc. I understand that I am responsible for any and all charges not covered by my insurance provider, including any deductible, copayment or coinsurance as directed by my health insurance carrier(s).

PATIENT SIGNATURE:_____ Date: _____

Patient acknowledgment: After testing is completed, your remaining sample may be used for research purposes, such as the development of testing procedures and/or standards.

PATIENT SIGNATURE:_____ Date: _____