Complete and print.

Reset Form

D 2 P R E Q

MAYO CLINIC LABORATORIES

Gastroenterology and Hepatology Patient Insurance Test Request

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Street Address		
City	State	ZIP Code

Submitting Provider Information (required)

Submitting/Referring Provider Name *(Last, First)*

Fill in only if Call Back is required.

Phone (with area code)	Fax* (with area code)
Provider's National I.D. (NPI)	

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Reason for Testing (required)

ICD-10 Diagnosis Code

Note: It is the client's responsibility to maintain documentation of the order.

New York State Patients: Informed Consent for Genetic Testing

"I hereby confirm that informed consent has been signed by an individual legally authorized to do so and is on file with this office or the individual's provider's office."

Signature ▶

Note: Test requests without a signature will not be performed.

Patient Information (required)

Patient ID (Medical Record No.)		
Patient Name *(Last, First, Middle)*		
Sex ☐ Male ☐ Female	Birth Date *(mm-dd-yyyy)*	
Collection Date *(mm-dd-yyyy)*	Time ☐ am ☐ pm	
Street Address		
City	State	ZIP Code
Phone		

Insurance Information

Subscriber Name (if different than patient)		
Relationship to Patient ☐ Spouse ☐ Dependent ☐ Other: _____		
Medicare HIC Number (if applicable)		
Medicaid Number (if applicable)		
Insurance Company Name (if applicable)		
Insurance Company Street Address		
City	State	ZIP Code
Policy Number		
Group Number		

MCL Internal Use Only

Ship specimens to:

Mayo Clinic Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Visit www.MayoClinicLabs.com for the most up-to-date test and shipping information.

Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

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Patient Information (required)

Patient ID (Medical Record No.)	Client Account No.
Patient Name *(Last, First, Middle)*	Client Order No.
Birth Date *(mm-dd-yyyy)*	

INFLAMMATORY BOWEL DISEASE

Diagnosis

- ☐ CALPR — Calprotectecin, Feces
- ☐ IBDP2 — Inflammatory Bowel Disease Serology Panel, Serum

Therapeutic Drug Monitoring

- ☐ ADALX — Adalimumab Quantitative with Reflex to Antibody, Serum
- ☐ INFXR — Infliximab Quantitation with Reflex to Antibodies to Infliximab, Serum
- ☐ CELI — Celiac Associated HLA-DQ Alpha 1 and DQ Beta 1 DNA Typing, Blood
- ☐ THIO — Thiopurine Metabolites, Whole Blood
- ☐ TPMT3 — Thiopurine Methyltransferase Activity Profile, Erythrocytes
- ☐ TPNUQ — Thiopurine Methyltransferase (TPMT) and Nudix Hydrolase (NUDT15) Genotyping, Varies
- ☐ USTEK — Ustekinumab Quantitation with Antibodies, Serum
- ☐ VEDOZ — Vedolizumab Quantitation with Antibodies, Serum
- ☐ VEDOL — Vedolizumab Quantitation with Reflex to Antibodies, Serum

Monogenetic Inflamatory Bowel Disease (IBD)

- ☐ IBDGP — Inflammatory Bowel Disease Primary Immunodeficiency (PID) Panel, Varies

CELIAC DISEASE

- ☐ CELI — Celiac Associated HLA-DQ Alpha 1 and DQ Beta 1 DNA Typing, Blood
- ☐ CDCOM — Celiac Disease Comprehensive Cascade, Serum and Whole Blood
- ☐ CDGF — Celiac Disease Gluten-Free Cascade, Serum and Whole Blood
- ☐ CDSP — Celiac Disease Serology Cascade, Serum

INTESTINAL INFECTION

GI Pathogens

- ☐ GIP — Gatrointestinal Pathogen Panel, PCR, Feces

Helicobacter pylori

- ☐ UBT — *Helicobacter pylori* Breath Test
- ☐ HELIS — *Helicobacter pylori* Culture with Antimicrobial Susceptibilities, Varies
- ☐ HPFRP — *Helicobacter pylori* with Clarithromycin Resistance Prediction, Molecular Detection, PCR, Feces
- ☐ HPCRP — *Helicobacter pylori* with Clarithromycin Resistance Prediction, Molecular Detection, PCR, Varies

MALABSORPTION DISORDERS

- ☐ 7AC4 — 7AC4, Bile Acid Synthesis, Serum
- ☐ DSAC — Disaccharidase Activity Panel, Tissue
- ☐ FATF — Fat, Feces
- ☐ ELASF — Pancreatic Elastase, Feces

MOTILITY DISORDERS

- ☐ GID2 — Autoimmune Gastrointestinal Dysmotility Evaluation, Serum

LIVER DISORDERS

- ☐ FIBRO — FibroTest-ActiTest, Serum
- ☐ NSFIB — Nonalcoholic Steatohepatitis (NASH)-FibroTest, Serum and Plasma

HEPATOCELLULAR CARCINOMA (HCC)

- ☐ L3AFP — Alpha-Fetoprotein (AFP) L3% and Total, Hepatocellular Carcinoma Tumor Marker, Serum
- ☐ DCP — Des-Gamma-Carboxy Prothrombin (DCP), Serum
- ☐ HCCGS — Hepatocellular Carcinoma Risk Panel with GALAD Score, Serum; Includes:
  - AFP-L3% and total alpha fetoprotein
  - Des-gamma-carboxy prothrombin
  - GALAD Score calculation

ADDITIONAL TESTS (INDICATE TEST CODE AND NAME)

For Complete GI Test Catalog Visit:
news.mayocliniclabs.com/gastroenterology/

Print

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