TEST REQUISITION FORM
(MEDICARE Use Only)
BD-F-048v1 10-19-2026

IGeneX Inc.
556 Gibraltar Drive | Milpitas | CA 95035 - 6315 | T: (800) 832-3200 | F: (408) 935-8272 | www.igenex.com
CLIA Number: 05D0643914 • NPI: 1396837605 • CA License: CLF4033 • Federal Tax ID: 94-3147701

Lab Use Only

MEDICAL NECESSITY REQUIREMENTS

- **Individual tests only.** Each test is performed, reported, and billed separately under its own CPT code. Check only the medically necessary tests on pages 2 & 3; only checked tests will be performed and billed.
- **Medical necessity:** Medicare covers only tests that are reasonable and necessary for the patient's diagnosis or treatment, not screening. The ordering practitioner must be treating the patient, use the results in their care, and be enrolled in Medicare (PECOS).
- **Diagnosis codes**: The ordering provider must supply ICD-10-CM code(s), to the highest specificity, for each test, supported by the medical record. IGeneX does not assign or recommend diagnosis codes.

PATIENT INFORMATION (REQUIRED – testing will be placed on hold if incomplete)

Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip

Telephone	Email	Gender ☐ Female ☐ Male	Date of Birth (MM-DD-YYYY)

MEDICARE INFORMATION – Please select one (REQUIRED): Please note: IGeneX, Inc. does not accept assignment from Health Insurance Providers, Medi-Cal or Medicaid.

☐ **Medicare is my Primary Insurance**
MBI (Medicare Number):
- Attach a copy of front & back of Medicare and/or Insurance card
- Complete and sign the attached ***Medicare Patient Insurance Information Form***

☐ **Medicare is my Secondary (Supplemental) Insurance**

☐ **I am enrolled in a Medicare Advantage (Senior) Plan**

☐ **NO, I do not have Medicare Medical (Part B) Coverage** (Use Domestic TRF)

ADVANCE BENEFICIARY NOTICE (ABN) ☐ **Signed ABN attached** ☐ **ABN not applicable**
An ABN is **required in advance for all Medicare beneficiaries** when any cePCR (Culture enhanced) test is ordered. **Please attach a copy of the signed ABN to this requisition.**

☐ **Credit Card** ☐ **Check Number:**

Credit Card Number:	Expiration Date:

Card Holder's Name:	Billing Zip Code:

By signing, I authorize IGeneX, Inc. to submit claims to Medicare and/or my insurance carrier on my behalf for the services provided, and to release any information required to process those claims. I understand that Medicare pays only for tests that are reasonable and medically necessary. If I signed an Advance Beneficiary Notice (ABN) for a test, I understand that I am responsible for payment to IGeneX, Inc. if Medicare denies coverage for that test. If I am enrolled in a Medicare Advantage Plan, I understand that IGeneX, Inc. is an out-of-network provider and I am responsible for any amounts not covered by my plan.

SIGN and DATE HERE **Required to process test(s)**

PATIENT or RESPONSIBLE PARTY'S SIGNATURE

TODAY'S DATE

REFERRING PHYSICIAN/LABORATORY INFORMATION (REQUIRED – testing will be placed on hold if incomplete)

Physician/Laboratory	Credentials

Primary Practice Address	City	State	Zip

Telephone	Fax Number	Email	NPI (Required)

ICD-10-CM Codes (Required): *Provide all applicable ICD-10-CM code(s), coded to the highest level of specificity, supporting EACH test ordered.*

Lyme *(Borrelia burgdorferi)*: ; ;	**Babesiosis:** ; ;	**Ehrlichiosis and Anaplasmosis:** ; ;
TBRF: ; ;	**Bartonellosis:** ; ;	**Rickettsiosis:** ; ;

By signing, I confirm that I am the treating/referring physician for this patient and that the tests selected on this requisition are the tests I am ordering. I attest that these tests are medically necessary based on my clinical judgment and that the medical necessity for each test is documented in the patient's medical record. I understand that Medicare reimburses only those tests that are reasonable and necessary, and that ordering medically unnecessary tests may result in liability, including potential penalties under the False Claims Act and enforcement actions by the Office of Inspector General (OIG). I acknowledge that claims may be reviewed or audited by CMS or its contractors.

SIGN and DATE HERE **Required to process test(s)**

REFERRING PHYSICIAN'S SIGNATURE

TODAY'S DATE

Please mark individual test(s) on pages 2 & 3 ▶

DRAWING LABORATORY INFORMATION (REQUIRED for claim submission – Place of Service)

Laboratory	Main Contact	Telephone	Fax Number

Street Address	City	State	Zip

Specimen Collection Performed By:	Collection Date: (MM-DD-YYYY)	Send copy of test results? ☐ YES ☐ NO	Charged for venipuncture fee? ☐ YES ☐ NO

SPECIMEN INFORMATION Reminder: Patient's Last Name, First Name, Collection Date and Date of Birth must be on tube labels.

☐ SERUM (SST)	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer
☐ WHOLE BLOOD (EDTA) #1	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer
☐ WHOLE BLOOD (EDTA) #2	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer
☐ WHOLE BLOOD (HEPARIN)	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer
☐ URINE Sample #1	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer
☐ URINE Sample #2	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer
☐ URINE Sample #3	Collection Date: / /	Storage: ☐ Room Temp ☐ Refrigerator ☐ Freezer

☐ MISCELLANEOUS
Type:
Collection Date: / /
Preservative:
Storage:
☐ Room Temp ☐ Refrigerator ☐ Freezer

INDIVIDUAL TESTS MENU

Visit www.igenex.com for the most up-to-date test information.

Patient Information (required)	
Name (*Last, First, Middle Initial*)	Date of Birth (MM/DD/YYYY)

▶ **Effective 01/01/2027, Lyme ImmunoBlot IgM/IgG will be billed under CPT 86617 (replacing 0041U/0042U) and TBRF ImmunoBlot IgM/IgG under CPT 86619 (replacing 0043U/0044U).**

	TEST CODE	TEST NAME	CPT/HCPCS CODE(S)	TUBE(S)/SPECIMEN REQUIREMENTS
▶ LYME (*Borrelia burgdorferi*)				
☐	183	**Lyme Serology IgG, IgM**	86618	1 SST/ minimum volume 0.5mL serum
☐	*300	[1]**Lyme IGXSpot**	86352	1 Full Heparin Must be received within 48 hours of collection at RT
☐	325	**Lyme ImmunoBlot IgM (Genus)**	0041U	1 SST/ minimum volume 0.5mL serum
☐	*BBUSM	**Lyme IB IgM Speciation *B. burgdorferi* B31 *and* 297**	86609	1 SST/ Must be ordered in conjunction with Test 325 – Lyme IB IgM (Genus)
☐	*BBCAM	**Lyme IB IgM Speciation *B. Californiensis, B. mayonii, B. bisetti***	86609	Performed and billed only if Test 325 is positive
☐	335	**Lyme ImmunoBlot IgG (Genus)**	0042U	1 SST/ minimum volume 0.5mL serum
☐	*BBUSG	**Lyme IB IgG Speciation *B. burgdorferi* B31 *and* 297**	86609	1 SST/ Must be ordered in conjunction with Test 335 – Lyme IB IgG (Genus)
☐	*BBCAG	**Lyme IB IgG Speciation *B. Californiensis, B. mayonii, B. bisetti***	86609	Performed and billed only if Test 335 is positive
☐	450	**Lyme Multiplex PCR, Urine**	87801	Urine – BD Gray Top/ 4mL x2
☐	453	**Lyme Multiplex PCR, Serum**	87801	1 SST/ minimum volume 2mL serum
☐	456	**Lyme Multiplex PCR, Whole Blood**	87476	1 Full EDTA
☐	*462	**Lyme Multiplex PCR, Miscellaneous**	87801	2-3 cm/tissue, or 3mL/fluid
☐	465	**Lyme Multiplex PCR, Urine (pooled)**	87801	Urine – BD Gray Top/ 4mL x6 (2 tubes per collection day)
☐	*601	**Broad Coverage Lyme Ab Assay**	86618	1 SST/ minimum volume 0.5mL serum
☐	605	**Lyme Screen Immunoassay IgM**	86618	1 SST/ minimum volume 0.5mL serum
☐	606	**Lyme Screen Immunoassay IgG**	86618	1 SST/ minimum volume 0.5mL serum
☐	*1100C	**Lyme cePCR (Culture enhanced)** • Blood Culture • *Borrelia*	87999 87476	1 Full EDTA ABN and prepayment required in advance for all Medicare beneficiaries
▶ TICK-BORNE RELAPSING FEVER (TBRF) *Borrelia*				
☐	345	**TBRF ImmunoBlot IgM (Genus)**	0043U	1 SST/ minimum volume 0.5mL serum
☐	TBMM	**TBRF IB IgM Speciation *B. miyamotoi***	86609	1 SST/ Must be ordered in conjunction with Test 345 – TBRF IB IgM (Genus)
☐	TBHM	**TBRF IB IgM Speciation *B. hermsii***	86609	Performed and billed only if Test 345 is positive
☐	TBTM	**TBRF IB IgM Speciation *B. turicatae***	86609	
☐	355	**TBRF ImmunoBlot IgG (Genus)**	0044U	1 SST/ minimum volume 0.5mL serum
☐	TBMG	**TBRF IB IgG Speciation *B. miyamotoi***	86609	1 SST/ Must be ordered in conjunction with Test 355 – TBRF IB IgG (Genus)
☐	TBHG	**TBRF IB IgG Speciation *B. hermsii***	86609	Performed and billed only if Test 355 is positive
☐	TBTG	**TBRF IB IgG Speciation *B. turicatae***	86609	
☐	556	**TBRF and *B. burgdorferi* sensu lato real-time PCR, Whole Blood** • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87798 87798 87798 87798	1 Full EDTA
☐	559	**TBRF and *B. burgdorferi* sensu lato real-time PCR, Urine** • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87798 87798 87798 87798	Urine – BD Gray Top/ 4mL x2
☐	562	**TBRF and *B. burgdorferi* sensu lato real-time PCR, Urine (pooled)** • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87798 87798 87798 87798	Urine – BD Gray Top/ 4mL x6 (2 tubes per collection day)
☐	*568	**TBRF and *B. burgdorferi* sensu lato real-time PCR, Miscellaneous** • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87798 87798 87798 87798	2-3 cm/tissue, or 3mL/fluid
☐	573	**TBRF and *B. burgdorferi* sensu lato real-time PCR, Serum** • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87798 87798 87798 87798	1 SST/ minimum volume 2mL serum
☐	*602	**Broad Coverage TBRF *Borrelia* Ab Assay**	86619	1 SST/ minimum volume 0.5mL serum
☐	*1200C	**RFB & Bbsl cePCR (Culture enhanced)** • Blood Culture • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87999 87798 87798 87798 87798	1 Full EDTA ABN and prepayment required in advance for all Medicare beneficiaries
▶ BABESIOSIS				
☐	200	***B. microti* IgM & IgG IFA with reflex to titer** • *B. microti* antibody IgM • *B. microti* antibody IgG	86753 86753	1 SST/ minimum volume 0.5mL serum
☐	*609	**Broad Coverage *Babesia* Ab Assay**	86753	1 SST/ minimum volume 0.5mL serum
☐	640	***Babesia* FISH**	88365	1 Full EDTA – do not freeze
	400	[1]***Babesia* IGXSpot** [coming soon]	86352	1 Full Heparin Must be received within 48 hours of collection at RT
☐	663	***Babesia* PCR – Whole Blood** • *B. microti* PCR • *B. duncani* PCR	87469 87798	1 Full EDTA
☐	*665	***Babesia* PCR – Urine** • *B. microti* PCR • *B. duncani* PCR	87469 87798	Urine – BD Gray Top/ 4mL x2
☐	*720	***B. duncani* IgM & IgG IFA with reflex to titer** • *B. duncani* antibody IgM • *B. duncani* antibody IgG	86753 86753	1 SST/ minimum volume 0.5mL serum

*Tests are not yet available for New York Residents.

[1] Heparin Tube must be received within 48 hours of collection at room temperature.

[2] Only *R. rickettsii* will be reported for New York residents.

[3] Billed under CPT 88364 (each additional single probe stain procedure) when ordered on the same date of service as Test 640 – *Babesia* FISH.

INDIVIDUAL TESTS MENU

Visit www.igenex.com for the most up-to-date test information.

Patient Information (required)	
Name (*Last, First, Middle Initial*)	Date of Birth (MM/DD/YYYY)

BABESOSIS (continued)

☐	900S	***Babesia* ImmunoBlot IgM (Genus)**	86753	1 SST/ minimum volume 0.5mL serum
☐	900M	***Babesia* IB IgM Speciation *B. microti* IgM**	84182	1 SST/ Must be ordered in conjunction with Test 900S – Babesia IB IgM (Genus)
☐	900D	***Babesia* IB IgM Speciation *B. duncani* IgM**	86849	Performed and billed only if Test 900S is positive
☐	905S	***Babesia* ImmunoBlot IgG (Genus)**	86753	1 SST/ minimum volume 0.5mL serum
☐	905M	***Babesia* IB IgG Speciation *B. microti* IgG**	84182	1 SST/ Must be ordered in conjunction with Test 905S – Babesia IB IgG (Genus)
☐	905D	***Babesia* IB IgG Speciation *B. duncani* IgG**	86849	Performed and billed only if Test 905S is positive
☐	*1300C	***Babesia* cePCR (Culture enhanced)** • Blood Culture • *B. microti* PCR • *B. duncani* PCR	87999 87469 87798	1 Full EDTA ABN and prepayment required in advance for all Medicare beneficiaries

BARTONELLOSIS

☐	280	***B. henselae* PCR, Whole Blood**	87471	1 Full EDTA
☐	*282	***B. henselae* PCR, Urine**	87471	Urine – BD Gray Top/ 4mL x2
☐	285	***B. henselae* IgM & IgG IFA with reflex to titer** • *B. henselae* antibody IgM • *B. henselae* antibody IgG	86611 86611	1 SST/ minimum volume 0.5mL serum
☐	*289	[3]***Bartonella* FISH**	88365 (88364)	1 Full EDTA – do not freeze
☐	*350	[1]***Bartonella* IGXSpot**	86352	1 Full Heparin Must be received within 48 hours of collection at RT
☐	374S	***Bartonella* ImmunoBlot IgM (Genus)**	86611	1 SST/ minimum volume 0.5mL serum
☐	374E	***Bartonella* IB IgM Speciation *B. elizabethae* IgM**	86611	
☐	374V	***Bartonella* IB IgM Speciation *B. vinsonii* IgM**	84182	1 SST/ Must be ordered in conjunction with Test 374S – Bartonella IB IgM (Genus)
☐	374H	***Bartonella* IB IgM Speciation *B. henselae* IgM**	84182	Performed and billed only if Test 374S is positive
☐	374Q	***Bartonella* IB IgM Speciation *B. quintana* IgM**	86849	
☐	384S	***Bartonella* ImmunoBlot IgG (Genus)**	86611	1 SST/ minimum volume 0.5mL serum
☐	384E	***Bartonella* IB IgG Speciation *B. elizabethae* IgG**	86611	
☐	384V	***Bartonella* IB IgG Speciation *B. vinsonii* IgG**	84182	1 SST/ Must be ordered in conjunction with Test 384S – Bartonella IB IgG (Genus)
☐	384H	***Bartonella* IB IgG Speciation *B. henselae* IgG**	84182	Performed and billed only if Test 384S is positive
☐	384Q	***Bartonella* IB IgG Speciation *B. quintana* IgG**	86849	
☐	*611	**Broad Coverage *Bartonella* Ab Assay**	86611	1 SST/ minimum volume 0.5mL serum
☐	*1400C	***Bartonella* cePCR (Culture enhanced)** • Blood Culture • *Bartonella* PCR	87999 87471	1 Full EDTA ABN and prepayment required in advance for all Medicare beneficiaries

EHRLICHIOSIS and ANAPLASMOSIS

☐	203	**HME (*Ehrlichia chaffeensis*) IgM & IgG IFA with reflex to titer** • HME antibody IgM • HME antibody IgG	86666 86666	1 SST/ minimum volume 0.5mL serum
☐	206	**HGA (*Anaplasma phagocytophilum*) IgM & IgG IFA with reflex to titer** • HGA antibody IgM • HGA antibody IgG	86666 86666	1 SST/ minimum volume 0.5mL serum
	500	[1] ***Anaplasma* IGXSpot** [coming soon]	86352	1 Full Heparin Must be received within 48 hours of collection at RT
☐	750	**HME (*Ehrlichia chaffeensis*) PCR, Serum**	87484	1 SST/ minimum volume 2mL serum
☐	755	**HGA (*Anaplasma phagocytophilum*) PCR, Serum**	87468	1 SST/ minimum volume 2mL serum
☐	770	**HME (*Ehrlichia chaffeensis*) PCR, Whole Blood**	87484	1 Full EDTA
☐	775	**HGA (*Anaplasma phagocytophilum*) PCR, Whole Blood**	87468	1 Full EDTA
☐	*780	**HME (*Ehrlichia chaffeensis*) PCR, Urine**	87484	Urine – BD Gray Top/ 4mL x2
☐	*785	**HGA (*Anaplasma phagocytophilum*) PCR, Urine**	87468	Urine – BD Gray Top/ 4mL x2
☐	*1500C	***Ehrlichia* and *Anaplasma* cePCR (Culture enhanced)** • Blood Culture • HME PCR • HGA PCR	87999 87484 87468	1 Full EDTA ABN and prepayment required in advance for all Medicare beneficiaries

RICKETTSIOSIS

☐	965	***R. rickettsii* & *R. typhi* IgG IFA with reflex to titer** • *R. rickettsii* antibody IgG • *R. typhi* antibody IgG	86757 86757	1 SST/ minimum volume 0.5mL serum
☐	*970	**Rickettsia PCR, Urine** • *R. rickettsii* PCR • *R. felis/typhi* PCR	87798 87798	Urine – BD Gray Top/ 4mL x2
☐	998	[2]**Rickettsia PCR, Whole Blood** • *R. rickettsii* PCR • *R. felis/typhi* PCR	87798 87798	1 Full EDTA
☐	*1600C	**Rickettsia cePCR (Culture enhanced)** • Blood Culture • *R. rickettsii* PCR • *R. felis/typhi* PCR	87999 87798 87798	1 Full EDTA ABN and prepayment required in advance for all Medicare beneficiaries

CENTRAL NERVOUS SYSTEM

☐	281	***B. henselae* PCR, CSF**	87471	2mL CSF
☐	*459	**Lyme Multiplex PCR, CSF**	87801	2mL CSF
☐	565	**TBRF and *B. burgdorferi* sensu lato real-time PCR, CSF** • Relapsing Fever *Borrelia* Genus • RF *Borrelia* Subgroup • *Borrelia burgdorferi* sensu lato • *Borrelia*	87798 87798 87798 87798	2mL CSF
☐	986	[2]**Rickettsia PCR, CSF** • *R. rickettsii* PCR • *R. felis/typhi* PCR	87798 87798	2mL CSF

*Tests are not yet available for New York Residents.

[1] Heparin Tube must be received within 48 hours of collection at room temperature.

[2] Only *R. rickettsii* will be reported for New York residents.

[3] Billed under CPT 88364 (each additional single probe stain procedure) when ordered on the same date of service as Test 640 – *Babesia* FISH.