

FAX TO

(210) 783-1079

RETURN TO
OncoBiomix — Orders TeamEMAIL
Contact@oncobiomix.comPHONE
210-745-1035WEB
www.oncobiomix.com

DATE

PAGES
1☐ Urgent ☐ New patient ☐ Referral ☐ Re-order

PATIENT INFORMATION

LAST NAME

FIRST NAME

DATE OF BIRTH

PRIMARY PHONE

STREET ADDRESS

CITY

STATE

ZIP

EMAIL

PRESCRIBING PROVIDER INFORMATION

PROVIDER NAME (LAST, FIRST, CREDENTIALS)

NPI

PHONE

FAX

PRACTICE / GROUP NAME

PRACTICE ADDRESS

CITY

STATE

ZIP

ORDER 1 — DIETITIAN (REGISTERED DIETITIAN) SERVICES

- ☒ Initial RD intake visit (60 min) — *included with enrollment*
- ☒ Auto-booked RD follow-up visits
- ☒ Additional ad-hoc visits as clinically needed — *\$99 per visit (cash pay)*

ORDER 2 — REBIOMIX™ GUT MICROBIOME TEST

- ☒ Initial REBIOMIX test — *one collection kit dispatched after Discovery call*

Refills: 4 kits total, dispatched as needed — *auto-scheduled with follow-ups · 12-mo authorization*

CLINICAL INDICATION

PRIMARY DIAGNOSIS (ICD-10)

CANCER TYPE / TREATMENT PHASE

ADDITIONAL CODES (OPTIONAL)

CLINICAL NOTES / SPECIAL INSTRUCTIONS

PROVIDER CERTIFICATION & SIGNATURE

I certify that the services and tests ordered above are medically necessary for the patient named above and authorize OncoBiomix to provide them. The patient will pay OncoBiomix directly (cash-pay program).

X

PROVIDER SIGNATURE

DATE

PRINTED NAME

NPI

CONFIDENTIALITY NOTICE

This facsimile transmission and any accompanying documents contain confidential information intended only for the individual or entity named above, and may contain protected health information (PHI) subject to HIPAA. If you are not the intended recipient, any disclosure, copying, distribution, or reliance on this information is strictly prohibited. If you received this transmission in error, notify the sender immediately at 210-745-1035 and destroy all copies.