ONCOBIOMIX

PROVIDER ORDER

FAX & ORDER — SINGLE PAGE

FAX TO
(210) 783-1079

RETURN TO: **OncoBiomiX — Orders Team**
EMAIL: **Contact@oncobiomix.com**
PHONE: **210-745-1035**
WEB: **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