SYN-ONE TEST® BENEFITS VERIFICATION FORM

Please select ONLY ONE of the test choices below. *A box must be marked to complete benefits verification*

☐ Syn-One Test panel: Synuclein + IENFD (PGP 9.5) + Skin morphology (H&E) + Amyloidosis (Congo red)

☐ Syn-One Test panel *excluding* Amyloidosis (Congo red): Synuclein + IENFD (PGP 9.5) + Skin morphology (H&E)

☐ Amyloidosis test only: Amyloidosis (Congo red) + Skin morphology (H&E)

All fields are required. Incomplete information will result in significant delays.

Patient Information

Legal First Name	Middle Initial	Legal Last Name	Date of Birth (MM/DD/YYYY)
Email Address	Cell Phone Number	Phone Number	Sex at Birth Male ☐ Female ☐
Street Address	City	State	Zip Code
Policy Holder First and Last Name, if other than patient		Policy Holder Date of Birth, if other than patient (MM/DD/YYYY)	

Primary Diagnosis and Relevant Diagnoses	Biopsy Scheduling
ICD-10 Code(s)	Date of Biopsy

Provider Information

Ordering Clinician		Clinician NPI Number	Email Address	Medicare Enrolled Yes ☐ No ☐
Practice Name		Practice Phone Number	Practice Fax Number	
Practice Street Address		City	State	Zip Code
Is this a referral patient? Yes ☐ No ☐	Referring Clinician Name	Referring Clinician Phone Number	Referring Clinician Fax Number	

PLEASE INCLUDE COPIES OF ALL THE INFORMATION BELOW AND FAX TO 480-569-2910

✓ **Insurance Cards (Primary and Secondary – Front and Back)** ✓ **Government Issued ID (Front and Back)**
✓ **Relevant Medical Records/Last Visit Note** ✓ **Patient Demographic Information (e.g., Face Sheet)**

Include support in the patient's medical records for why this test is **reasonable and necessary for the diagnosis or treatment** of the patient and describe **how test results may be used to guide the diagnosis or ongoing management** of the patient.

I certify I am authorized to order this test, which is medically necessary and that the results will guide medical management and treatment of this patient. I will make supporting records available detailing the above.

Provider Signature ______________________________ Date ____________________

INSURANCE BENEFITS VERIFICATION PROCESS

BV REQUEST SUBMITTED
Send completed form and supporting documents

ACCOUNT ENROLLMENT
Patient receives text and verifies their information

COVERAGE CHECK
CND verifies coverage and calculates OOP cost

PRIOR AUTHORIZATION
If required, CND will attempt to initiate an authorization

BV COMPLETE
Office and patient receive coverage and cost estimate*

SCHEDULE TEST
Contact patient to confirm biopsy appointment

Please let your patient know that CND may send text updates about insurance benefits verification and biopsy scheduling. They may receive 2–4 secure, real-time messages based on their situation and can opt out at any time or choose phone calls instead.

*Please note that benefits verification and/or prior authorization obtained by CND does not guarantee insurance payment.

ICD-10-CM CODES

A list of common ICD-10-CM codes can be found at cndlifesciences.com/icd-10-cpt-codes. Clinicians must select medically necessary diagnoses based on the patient's documented signs and symptoms. This list is for reference only and does not recommend specific codes. For a full list, consult the ICD-10-CM manual at www.cdc.gov/nchs/icd/icd-10-cm

CND is here to support you. Please contact the Patient Access team at patientaccess@cndlifesciences.com