SMALL-FIBER DX™ BENEFITS VERIFICATION FORM

☐ Small-Fiber Dx™ Panel for Small Fiber Neuropathy

Small-Fiber Dx is an anatomical pathology test to objectively visualize and measure intraepidermal nerve fiber density (IENFD) to support a diagnosis of small fiber neuropathy.
Small-Fiber Dx includes a modified Congo Red stain to identify amyloid deposition to support a diagnosis of amyloidosis and hematoxylin and eosin (H&E) for skin histology.

Individual Test Options ☐ IENFD (PGP 9.5) + Skin histology (H&E) ☐ Amyloidosis (Congo Red) + Skin histology (H&E)

INCLUDE ALL INFORMATION BELOW TO AVOID PROCESSING DELAYS. PROCESSING MAY NOT PROCEED IF NOT INCLUDED. FAX TO (480) 569-2910.

☐ Primary insurance card (front/back) ☐ Government issued ID (front/back) ☐ Patient demographic information (face sheet, etc.)
☐ Secondary insurance card (front/back) ☐ Relevant medical records ☐ Nerve conduction study (if available) ☐ Assignment of benefits

If required by insurance company, CND will attempt to submit a prior authorization or notify the appropriate provider to initiate the request.
A benefits verification or prior authorization obtained by CND does not guarantee eventual payment by the insurance company.
CPT codes for standard Small-Fiber Dx panel: 88305 x 3, 88314 x 3, 88346 x 2, 88350 x 1, 88356 x 3
Codes and units reflect standard biopsy sites and number of biopsies. Codes and units may vary if non-standard number of biopsies are used.

PATIENT INFORMATION

First Name | Middle Initial | Last Name / Surname

Phone Number | Date of Birth (Month/Day/Year)

Sex at Birth
☐ Male
☐ Female
Gender Identity: _____

ICD-10 Codes
☐ G60.3 Idiopathic Neuropathy
☐ M79.2 Neuralgia & Neuritis, Unspecified
☐ Other: _____

Email Address

Primary Insurance Name/Member ID | Secondary Insurance Name/Member ID | Other Insurance Name/ Member ID | Scheduled Date of Biopsy

PRACTICE INFORMATION

Ordering Physician/Clinician | Physician NPI (US) or Clinician ID Number (International)

Practice Name

Street Address

City | State

ZIP or Postal Code

☐ US
☐ International

Country (International Only)

Phone Number | Fax Number

Email Address

Preferred Contact Method
☐ Email
☐ Fax

the undersigned certifies that he/she is licensed to order the test(s) selected and that such test(s) are medically necessary for the care/treatment of this patient and that the patient has agreed to the benefits verification process for the test(s) selected.

Authorized Signature | Date

CND Life Sciences | 9165 E Del Camino Dr., Ste 101 Scottsdale, AZ 85258-4381 | cndlifesciences.com | Phone: 480.569.2900 | Fax: 480.569.2910 | CLIA# 03D2151444