SYN-ONE TEST® BENEFITS VERIFICATION FORM

☐ Syn-One Test® for Synucleinopathy

Syn-One is an anatomical pathology test to detect, visualize, and quantify the presence of abnormal, phosphorylated alpha-synuclein in cutaneous nerve fibers to support a diagnosis of a synucleinopathy: Parkinson's disease (PD), dementia with Lewy bodies (DLB), multiple system atrophy (MSA), pure autonomic failure (PAF), or REM sleep behavior disorder (RBD). Syn-One is also able to confirm and quantify the density of intraepidermal nerve fibers to support a diagnosis of small fiber neuropathy. For other important insights, Syn-One also includes modified Congo Red staining to identify amyloid proteins to support a diagnosis of amyloidosis and hematoxylin and eosin for skin histology.

Individual Test Options ☐ Synuclein + Skin histology (H&E) ☐ Synuclein + 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 ☐ 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 Syn-One Test panel: 88305 x 3, 88314 x 3, 88346 x 2, 88350 x 4, 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 Code Information
☐ G60.3 Idiopathic Neuropathy
☐ G20 Parkinsonism
☐ 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 _____

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