

SMALL-FIBER DX® BENEFITS VERIFICATION FORM



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

- Small-Fiber Dx panel: IENFD (PGP 9.5) + Skin morphology (H&E) + Amyloidosis (Congo red)
- Small-Fiber Dx *excluding* Amyloidosis (Congo red): 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 <input type="checkbox"/> Female <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
Practice Name	Practice Phone Number	Practice Fax Number	
Practice Street Address	City	State	Zip Code
Is this a referral patient? Yes <input type="checkbox"/> No <input type="checkbox"/>	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