



Licensed for Clinical Revolution and Trusted by Leading Institutions

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HEALTHIEONE TEST AUTHORIZATION

PROVIDER INFORMATION

Provider NPI:

Provider Name:

Practice/Clinic Name:

Address:

Phone:

Email:

License Number:

License State:

PATIENT INFORMATION

Patient Name:

Date of Birth:

Sex Assigned at Birth: Male Female

Address:

Phone:

Email:

BILLING INFORMATION

Billing Type (Select One):

Insurance Medicare

TEST SELECTION

HealthieOne Complete (*Comprehensive Annual Health Test*)

HealthieOne Follow-up (*Retest abnormal markers*)

- HealthieOne Disease Specific | Specify: _____
- HealthieOne Advanced Glucose (*Specialty testing for athletes*)
- HealthieOne Advanced Cholesterol (*Specialty testing for athletes*)
- HealthieOne Advanced Protein (*Specialty testing for athletes*)

ICD-10 DIAGNOSIS CODES

Required for Insurance/Medicare Billing:

PROVIDER SIGNATURE AND AUTHORIZATION

Electronic Signature Authorization:

I hereby authorize Gigantest, Inc. to use the signature provided below as my authentic signature for all test orders I submit. I acknowledge that this signature is required for submitting claims to insurance providers and Medicare. This authorization will remain in full force and effect until I revoke it through written notice.

Date:

Healthcare Practitioner's Signature:

Questions? info@healthieone.com or [Live Chat](#) for instant assistance.

We are available 7 days a week from 9:00 AM to 11:30 PM EST.