

# Consumer Test and Fee Schedule

CPT (Procedure) Codes	BLOOD SPOT TESTS AND PROFILES	ZRT Retail	Discount
82670	Estradiol (E2, total)	45	35
84144	Progesterone (Pg, total)	45	35
84305	Somatomedin C (IGF-1)	115	85
84443	Thyroid Stimulating Hormone (TSH)	75	69
84481	Triiodothyronine (freeT3)	75	69
84439	Thyroxine (freeT4)	75	69
86376	Thyroid Peroxidase Antibody (TPO)	75	69
83002	Luteinizing Hormone (LH)	60	46
83001	Follicle Stimulating Hormone (FSH)	60	46
84153	Prostate Specific Antigen (PSA)	50	40
84270	Sex Hormone Binding Globulin (SHBG)	90	85
84403	Testosterone (T, total)	45	35
82627	DHEA-S (DS)	45	35
82533	Cortisol (Cx1)	45	35
83525	Fasting Insulin	45	35
86141	High Sensitivity C-Reactive Protein (hsCRP)	60	57
83036	Hemoglobin A1c (HbA1c)	60	57
84478	Triglycerides (TG)	60	57
82306	Vitamin D 25-OH, Total	100	75
83525, 86141, 83036, 84478, 82465, 83718	CardioMetabolic Profile I (Insulin, hsCRP, HbA1c, TG, CH, HDL, LDL, VLDL)	255	184
84443, 84481, 84439, 86376	Complete Thyroid Profile TSH, ft3, ft4, TPO	300	276
82670, 84144, 84403, 84270, 82627, 82533	Female Blood Profile I E2, Pg, T, SHBG, DS, C	315	189
82670, 84144, 84403, 84270, 82627, 82533, 84443, 84481, 84439, 86376	Female Blood Profile II E2, Pg, T, SHBG, DS, C, TSH, ft3, ft4, TPO	615	349
82670, 84403, 84153, 84270, 82627, 82533	Male Blood Profile I E2, T, PSA, SHBG, DS, C	320	189
82670, 84403, 84153, 84270, 82627, 82533, 84443, 84481, 84439, 86376	Male Blood Profile II E2, T, PSA, SHBG, DS, C, TSH, ft3, ft4, TPO	620	349
CPT (Procedure) Codes	SALIVA TESTS AND PROFILES	ZRT Retail	Discount
82670	Estradiol (E2)	45	35
82677	Estriol (E3)	45	35
82679	Estrone (E1)	45	35
84144	Progesterone (Pg)	45	35
84402	Testosterone (T)	45	35
82627	DHEA-S	45	35
82530	Cortisol (C)	45	35
82530 X 4	Diurnal Cortisol 4 tubes (Cortisol: morning, noon, evening, night)	180	138
82670, 84144, 84402, 82627, 82530	Female/Male Saliva Profile I (5 tests) (E2, Pg, T, DHEA-S, am Cortisol)	225	170
82670, 84144, 84402, 82627, 82530x2	Female/Male Saliva Profile II (6 tests) (E2, Pg, T, DHEA-S, am/pm Cortisol)	270	200
82670, 84144, 84402, 82627, 82530x4	Female/Male Saliva Profile III (8 tests) (E2, Pg, T, DHEA-S, Cx4)	360	260
CPT (Procedure) Codes	COMBINATION PROFILES	ZRT Retail	Discount
82670, 84144, 84402, 82627, 82530 x 4, 84443, 84481, 84439, 86376	Comprehensive Female Profile I Saliva: E2, Pg, T, DHEA-S & Cx4 Blood Spot: TSH, ft3, ft4, TPO	660	345
82530 x 4, 82670, 84144, 84403, 84270, 82627, 82533, 84443, 84481, 84439, 86376	Comprehensive Female Profile II Saliva: Cx4 Blood Spot: E2, Pg, T, SHBG, DS, TSH, ft3, ft4, TPO	750	380
82670, 84402, 82627, 82530 x 4, 84153, 84443, 84481, 84439, 86376	Comprehensive Male Profile I Saliva: E2, T, DS, Cx4 Blood Spot: PSA, TSH, ft3, ft4, TPO	665	345
82530 x 4, 84443, 84481, 84439, 86376, 82670, 84403, 82627, 84270, 84153	Comprehensive Male Profile II Saliva: Cx4 Blood Spot: E2, T, DS, SHBG, PSA, TSH, ft3, ft4, TPO	755	380
82670, 84144, 84402, 82627, 82530 x 4, 84443, 84481, 84439, 86376, 83001, 83002	Fertility Profile I Saliva: E2, Pg, T, DHEA-S & Cx4 Blood Spot: TSH, ft3, ft4, TPO, FSH, LH	780	379
82530 x 4, 82670, 84144, 84403, 84270, 82627, 84443, 84481, 84439, 86376, 83001, 83002	Fertility Profile II Saliva: Cx4 Blood Spot: E2, Pg, T, SHBG, DS, TSH, ft3, ft4, TPO, FSH, LH	870	425

## Fees are payable in US Dollars

- Payment or insurance information for laboratory services is due at the time of service. If payment is enclosed with the specimen(s) you will receive the discounted rate listed above and handle your own insurance claim. Payment can be made by check, money order or credit card. For credit card payment, complete the Credit Card Authorization form enclosed.
  - If you submit insurance information to ZRT, we will **bill the insurance companies listed on the reverse side of this form at full retail price**. You are responsible for the full retail price minus the amount paid by insurance (if any). For insurance billing, complete the Insurance Authorization form located on the reverse side of this page.
  - If no payment is received or if the submitted insurance information is incomplete, it will result in a delay in reporting your results, and you will be billed directly at full retail price.**
- \* **FOR MEDICARE PATIENTS:** No prepayment is necessary. Please send all required Medicare insurance information with your specimen.
- \*\* **FOR RESIDENTS OF NEW YORK STATE,** New York State health law prohibits the transmission of data from our laboratory to NY residents; therefore we cannot bill insurance, or provide a statement for insurance purposes.

# Insurance Authorization

Read, complete, sign and return form.

ZRT Laboratory, LLC is a contracted provider of the following insurance companies:

1. PersonalCare Insurance of Illinois
2. First Health
3. CCN Network
4. Cook Group Health Plan

It is your responsibility to verify laboratory benefit coverage with your insurance company prior to testing.

ZRT Laboratory, LLC will courtesy bill the following insurance companies as a non-participating provider:

1. Medicare Part B
2. Medicare Private Fee For Service
3. Cigna
4. Medical Mutual
5. TriCare
6. Humana

It is your responsibility to verify out-of-network benefit coverage with your insurance company prior to testing. If your insurance company does not cover the full cost of testing, the entire remaining balance is your responsibility. Since ZRT Laboratory, LLC is a non-participating provider these insurance companies will be billed at full retail price.

You may wish to prepay for services to receive the discounted rate and handle your own insurance claim. Upon receipt of payment in full, ZRT Laboratory, LLC will provide you with an insurance receipt. You may submit this receipt to your insurance company for reimbursement (in accordance with your health plan benefit coverage).

You are directly responsible to ZRT Laboratory, LLC for payment. The lab does not accept responsibility for disputed, denied or unpaid insurance claims.

The following information, along with this signed authorization form, must be sent with your sample in order for ZRT Laboratory, LLC to bill insurance on your behalf.

- Complete address
- Date of birth
- Physician prescription
- Diagnosis code (ICD-9) from your physician written on the requisition form or on your prescription
- Physician's full printed name and address
- Photo copy of front and back of your primary insurance card

Group number: \_\_\_\_\_ ID number: \_\_\_\_\_

Claims mailing address: \_\_\_\_\_

**Failure to provide all information required to bill insurance will result in your being billed directly at full retail price**

I acknowledge that I am financially responsible for all charges not paid by insurance. If it becomes necessary for ZRT Laboratory, LLC to pursue collections for the amount due, I agree to pay for all cost and expenses incurred in the collection process. I hereby authorize ZRT Laboratory, LLC to release or obtain, from my physician, any information deemed necessary to process my insurance claim (e.g. insurance cards, diagnosis codes, and/or order for lab work). I authorize my insurance company to make payment of medical benefits directly to ZRT Laboratory, LLC. I understand that by authorizing ZRT Laboratory, LLC to bill my insurance I am no longer eligible to receive the prepaid discounted price.

Signature  \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

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