INDUSTRY LAB
FAST | ACCURATE | AFFORDABLE

Dear Valued Partner,

Industry Lab Diagnostic Partners (ILDP) requests your authorization to maintain your signature on file for use in connection with laboratory requisitions submitted by your office.

To support regulatory and billing requirements, ILDP maintains authorized physician signatures on file for laboratory testing ordered or referred by your office. This authorization allows ILDP to apply your signature to patient-specific laboratory requisitions without requiring a handwritten signature on each order, when permitted by applicable law, payer requirements, and documentation standards. Your signature will be used solely for authorized testing and maintained securely in accordance with HIPAA and CLIA requirements.

Please complete the authorization below to permit ILDP to maintain and use your signature on file.

PHYSICIAN AUTHORIZATION

By signing below, I authorize Industry Lab Diagnostic Partners to maintain my signature on file and to accept laboratory requisitions submitted by my office for patients under my care.

I understand and agree that:

1. Each requisition submitted by my office represents an individual order for the patient identified on that requisition and must identify the specific laboratory test(s) being ordered.
2. The requisition will identify me as the ordering provider and will include the patient-specific information and applicable diagnosis/clinical information necessary to support the laboratory services being ordered.
3. I authorize ILDP to use my signature on file solely for the purpose of processing patient-specific laboratory requisitions submitted by my office, when permitted by applicable requirements.
4. I am responsible for ensuring that the tests ordered for my patients are appropriate for the patient's condition and are reasonable and medically necessary when required by applicable payer or regulatory requirements.
5. My office will maintain appropriate documentation in the patient's medical record supporting my intent to order the laboratory test(s) and the medical necessity of the services, when required.
6. I understand ILDP will perform only the test(s) specifically requested on the submitted requisition and will not independently determine which tests are appropriate or medically necessary for my patient.
7. I understand applicable insurance coverage and payment are determined by the patient's insurance plan. ILDP may bill the applicable insurance, but payment is not guaranteed, and the patient may have financial responsibility when permitted by applicable law and payer requirements.
8. I understand this authorization does not constitute a blanket order for laboratory testing and does not authorize ILDP to perform testing that has not been specifically requested for an individual patient.
9. I understand any required patient consent, including informed consent for genetic testing when applicable, remains the responsibility of the ordering provider and/or the provider's office.
10. I understand that applicable diagnosis and clinical information must be accurately documented and submitted to ILDP to support the testing ordered.

Physician Name: _____ Individual NPI Number: _____

Signature: _____ Date: _____

Please return this completed form via fax to **513.860.0373** or email to **billing@ildp.com**. If you have any questions or need further information, please contact us at **513-866-7922.** Thank you for your continued trust and partnership.