Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

BERYLLIUM CLIENT REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name ______ First ______ MI ______

Address ______ Birth Date ______ Sex ☐ M ☐ F

City ______ SS # ______

State ______ Zip ______ Home Phone ______

Hospital/Physician Office Patient ID # ______ Accession # ______

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: ______/______/______

ABN: ☐ Yes ☐ No **WORKERS COMP:** ☐ Yes ☐ No DOI: ______

PRIMARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

SECONDARY: ☐ No ☐ Yes (if Yes, please attach)

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. ______ 2. ______ 3. ______

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name ______

Physician NPI# ______

Physician Phone ______

Physician Email ______

☐ Call results to phone number: (______) ______

☐ Fax report to: (______) ______

SPECIMEN INFORMATION

Collection Date: ____/____/____ Time: ______

Whole blood only

BERYLLIUM TESTING

☐ LPT to Beryllium, Blood *BLDBE*

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