

<p>PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p><small>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.</small></p> <p>INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p>PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p>ABN: <input type="checkbox"/> Yes <input type="checkbox"/> No WORKERS COMP: <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p>PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <hr/> <p>SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach)</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <hr/> <p>INDICATE TESTS REQUESTED (* limited coverage tests - ABN may be needed)</p> <table 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<p>Physician Name _____</p> <p>Physician NPI# _____</p> <p>Physician Phone _____</p> <p>Physician Email _____</p> <p>Physician Signature _____</p> <p><input type="checkbox"/> Call Results to phone number: (_____) _____</p> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <hr/> <p>SPECIMEN INFORMATION</p> <p>Collection Date: ____/____/____ Time: _____</p> <p>Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> Plasma</p> <p><input type="checkbox"/> Urine – volume _____ #hours _____</p> <p><input type="checkbox"/> Whole Blood <input type="checkbox"/> Other (specify) _____</p> <p><input type="checkbox"/> Fasting _____ hours <input type="checkbox"/> Non-fasting</p> <hr/> <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top; padding: 2px;"> <p><input type="checkbox"/> Stool Occult Blood Single Specimen *</p> <p><input type="checkbox"/> T Uptake *</p> <p><input type="checkbox"/> T3 Total *</p> <p><input type="checkbox"/> T4 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Difficile Assay</p> <p><input type="checkbox"/> Fungus Culture (hair, skin, nails)</p> <hr/> <p>ADDITIONAL TEST/COMMENTS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Stool Occult Blood Single Specimen *</p> <p><input type="checkbox"/> T Uptake *</p> <p><input type="checkbox"/> T3 Total *</p> <p><input type="checkbox"/> T4 Free *</p> <p><input type="checkbox"/> T4 *</p> <p><input type="checkbox"/> TIBC *</p> <p><input type="checkbox"/> Triglycerides</p> <p><input type="checkbox"/> Troponin</p> <p><input type="checkbox"/> TSH*/TSH 3rd Gen *</p> <p><input type="checkbox"/> Uric Acid</p> <p><input type="checkbox"/> Urinalysis with microscopic</p> <p><input type="checkbox"/> Urinalysis without microscopic</p> <p><input type="checkbox"/> Urine Drug Screen *</p> <p><input type="checkbox"/> Vancomycin _____ random</p> <p><input type="checkbox"/> Vitamin B12 *</p> <p><input type="checkbox"/> Vitamin D *</p> <p><input type="checkbox"/> WBC *</p>	<p><input 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