

BERYLLIUM CLIENT REQUISITION

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Address Birth Date Sex M F City SS # State Zīp Home Phone Hospital/Physician Office Patient ID # Accession # MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians for other individuals authorized by law to order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. INSURANCE BILLING INFORMATION (PLASE ATTACH CARD OR PRINT IN BLACK INK) BILL 10: Client/Institution Medicare Insurance (Complete insurance information below) Patient PATIENT STATUS: Inpatient Outpatient Non-Hospital Patient Hospital discharge date: /	PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)			CLIENT INFORMATION
State Zip Home Phone Hospital/Physician Office Patient ID # Accession # ORDERING PHYSICIAN CONTACT	Last Name	First	MI	
State	Address	Birth Date	Sex □ M □ F	
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 Physician NP!# PATIENT STATUS: Inpatient Outpatient Non-Hospital Patient Hospital discharge date:/ ABN: Ves No WORKERS COMP: Yes No DO!: Physician Email Physician Email Call results to phone number: First MI Beneficiary / Member # Group # Speciment of a patient Speciment of a patient, rather than for screening purposes. INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK) Physician Name Physi	City	SS #		
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 Physician NPI# Physician NPI# Physician NPI# Physician NPI# Physician NPIH Phy	State Zip	Home Phone		
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PATIENT STATUS: Inpatient Outpatient Non-Hospital Patient Hospital discharge date: /	law to order tests) should only order tests that are medically necessary for insurance billing information (please attach c	or the diagnosis or treatment of a patient, rather th ARD OR PRINT IN BLACK INK)	an for screening purposes.	
PRIMARY: Medicare Medicaid (Ohio only) Other Ins. Self Spouse Child Call results to phone number: (PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-H	Hospital Patient Hospital discharge date:		
Subscriber Last Name First MI Beneficiary / Member # Group # Claims Address City State Zip Whole blood only DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1			□ Spouse □ Child	Call results to phone number: ()
Claims Address City State Zip Whole blood only BERYLLIUM TESTING Collection Date:/ Time:	Subscriber Last Name	First	MI	
Claims Address City State Zip SECONDARY: No Yes (if Yes, please attach) DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. 2. 3. BERYLLIUM TESTING	Beneficiary / Member #	Group #		
DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1 2 3 BERYLLIUM TESTING	Claims Address	City State	Zip	
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