

HEAVY METAL REQUISITION DEMOGRAPHICS FORM

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)			CLIENT INFORMATION		
Last Name	First	MI			
Address	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F			
City	County	SS # (patients <6 years old)			
State	Zip	Home Phone			
Hospital/Physician Office Patient ID #					
THE STATE OF OHIO REQUIRES THE FOLLOWING INFORMATION WHEN ORDERING LEAD, CADMIUM, MERCURY OR ARSENIC					
ETHNICITY: <input type="checkbox"/> Unknown (:Z) <input type="checkbox"/> Hispanic (:H) <input type="checkbox"/> Non-Hispanic (:N) <input type="checkbox"/> Other (:O)					
RACE: <input type="checkbox"/> Unknown (:Z) <input type="checkbox"/> White (:W) <input type="checkbox"/> Black (:B) <input type="checkbox"/> Asian (:A) <input type="checkbox"/> Native American (:N)					
<input type="checkbox"/> Other _____					
Name of guardian/parent (if patient is under 16 years of age)					
PLEASE COMPLETE THE FOLLOWING SECTION WHEN A COPY OF INSURANCE CARD (FRONT AND BACK) IS NOT PROVIDED.					
PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid (OH only) <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child					
Subscriber Last Name	First	MI			
Beneficiary / Member #	Group #				
Claims Address	City	State	Zip		
SECONDARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid (OH only) <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child					
Subscriber Last Name	First	MI			
Beneficiary / Member #	Group #				
Claims Address	City	State	Zip		
WORKER'S COMPENSATION					
Claim#	Date of Injury	ABN: <input type="checkbox"/> No <input type="checkbox"/> Yes			
BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)					
BILL TO: <input type="checkbox"/> Client <input type="checkbox"/> Patient <input type="checkbox"/> Medicare <input type="checkbox"/> Other Insurance					
DIAGNOSIS CODE (REQUIRED) ICD-10 Codes					
1. _____	2. _____	3. _____			
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.					
INDICATE TESTS REQUESTED					
<input type="checkbox"/> Arsenic, Blood <i>ASB</i>	<input type="checkbox"/> Cadmium, Blood <i>CADM</i>	<input type="checkbox"/> Heavy Metals with Cadmium, Ur <i>UTXM4</i>	<input type="checkbox"/> Lead, Urine 24 Hour <i>ULEADQ</i>		
<input type="checkbox"/> Arsenic, Fractionated Urine <i>UASFR</i>	<input type="checkbox"/> Cadmium, Urine <i>URCAD</i>	<input type="checkbox"/> Heavy Metals with Cadmium, Whole Blood <i>HEVMT4</i>	<input type="checkbox"/> Mercury, Blood <i>MERC2</i>		
<input type="checkbox"/> Arsenic, Hair <i>ARSHR</i>	<input type="checkbox"/> Heavy Metals Screen, Whole Blood <i>HEVMET</i>	<input type="checkbox"/> Lead, Blood <i>LEAD2</i>	<input type="checkbox"/> Mercury, Urine 24 Hour <i>UMERC3</i>		
<input type="checkbox"/> Arsenic, Urine 24 Hr <i>UARSND</i>	<input type="checkbox"/> Heavy Metals, Urine <i>UTXM3</i>				

Ohio Administrative Codes 3701-30-05 and 3701-32-14 state that any physician or healthcare provider requesting analysis for lead, cadmium, arsenic or mercury shall complete each request with the above information.