



Patient Last Name		First	Middle Initial	Date of Service	Date Collected	Tech Code	Date of Draw or Pick-Up
Social Security #		Birthdate / /		Sex M F	Unit/Ward	Room/Bed	Time of Draw or Pick-Up AM PM
Doctor's Name				Doctor/Nurse Signature		Draw Site	
Patient Refused <input type="checkbox"/> Uncooperative <input type="checkbox"/>		Name of Assistant		<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> STAT	Total Miles	Total Draws
Stat Lab Information - Name of Stat Lab				Date Dropped		Time Dropped AM PM	

**BILLING INFORMATION MUST BE COMPLETED**

<input type="checkbox"/> MEDICARE			<input type="checkbox"/> MEDICAID			INSURANCE CO. NAME		
PREFIX	PATIENT MEDICARE I.D. NUMBER		SUFFIX	PATIENT MEDICAID I.D. NUMBER		INSURANCE CO. ADDRESS		
ACCOUNT BILLING <input type="checkbox"/> SKILLED MEDICARE PART "K"			<input type="checkbox"/> MANAGED CARE CONTRACT		<input type="checkbox"/> VA CONTRACT			INSURANCE CO. PHONE
<p><b>Advance Beneficiary Notice (ABN)</b> I understand that Medicare is likely to deny payment for certain tests because Medicare does not pay for this service for my condition. I understand that Medicare does not cover routine screens or annual physicals. I agree to be personally and fully responsible for payment of laboratory services if Medicare does not provide payment.</p> <p><input checked="" type="checkbox"/> Patient Signature</p>						INSURANCE ID. NO.		
						SUBSCRIBER'S NAME		
						GROUP NO.		

**DIAGNOSTIC INFORMATION**

<input type="checkbox"/> R	<input type="checkbox"/> RT	<input type="checkbox"/> G	<input type="checkbox"/> L	<input type="checkbox"/> S	<input type="checkbox"/> U	<input type="checkbox"/> B	<input type="checkbox"/> N	<input type="checkbox"/> Q	<input type="checkbox"/> H	<input type="checkbox"/> D	Medicare will not cover routine screening. A REASON (i.e. sign/symptom, diagnosis) "MUST" BE GIVEN FOR "ALL" TESTS. THE ICD9 CODE "MUST" BE LISTED BELOW.
PLAIN RED	RED TIGER	GRAY	LAV	SERUM	STERILE URINE	BLUE	GREEN	STOOL	24 HR. URINE	CULTURE SWAB	

**PROFILES**

**SPECIMEN**

<input type="checkbox"/> Basic CA, CO2, CL, CREAT, GLUC, K, NA, BUN	<input type="checkbox"/> Complete Blood Count and Tests <input type="checkbox"/> CBC with Platelet & Diff. <input type="checkbox"/> Hemogram <input type="checkbox"/> Clozaril Monitoring <input type="checkbox"/> Platelet Count CBC w/Platelet & Diff	<input type="checkbox"/> Acute HAAb, HbcAB, HbsAg, HBCAB	<input type="checkbox"/> Urinalysis <input type="checkbox"/> C. DIFF (Clostridium Difficile Toxin) <input type="checkbox"/> Ova and Parasite (STONP) <input type="checkbox"/> Stool for Occult Blood (STBLD) Number of specimens
<input type="checkbox"/> Comprehensive ALB, BILI, CA, CO2, CL, CREAT, GLUC, ALKPHOS, K, TP, NA, ALT, AST, BUN	<input type="checkbox"/> Clozaril Monitoring WBC <input type="checkbox"/> RBC <input type="checkbox"/> Differential <input type="checkbox"/> Sedimentation Rate (SEDRT) <input type="checkbox"/> Hematocrit (HCT) <input type="checkbox"/> Hemoglobin (HGB) <input type="checkbox"/> Sicklecoil <input type="checkbox"/> WBC	<input type="checkbox"/> Lipid Panel CHOL, HDL, TRIG	<input type="checkbox"/> Cultures and Sensitivity Only <input type="checkbox"/> MRSA Screen Only <input type="checkbox"/> VRE Screen Only (One source per requisition)
<input type="checkbox"/> Electrolyte CO2, CL, K, NA		<input type="checkbox"/> Renal ALB, CA, CO2, CL, CREAT, GLUC, PHOS, K, NA, BUN	Source: _____ For infection control reporting (circle one) Ward / Unit / Floor _____
<input type="checkbox"/> Hepatic ALB, BILI TOTAL, BILI DIRECT, ALKPHOS, TP, ALT, AST		Thyroid <input type="checkbox"/> T3 Uptake <input type="checkbox"/> T4 <input type="checkbox"/> TSH <input type="checkbox"/> Free T4	<input type="checkbox"/> Theophylline Aminophylline <input type="checkbox"/> Triglycerides <input type="checkbox"/> Uric Acid <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____

**ALPHABETICAL LISTING**

<input type="checkbox"/> Albumin	<input type="checkbox"/> Chloride	<input type="checkbox"/> FBS	<input type="checkbox"/> Hepatitis B, Surf. Antigen	<input type="checkbox"/> Lithium	<input type="checkbox"/> PT - INR
<input type="checkbox"/> Bilirubin, Direct	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Ferritin	<input type="checkbox"/> Folic Acid	<input type="checkbox"/> Phenobarbital	<input type="checkbox"/> PTT
<input type="checkbox"/> Bilirubin, Total	<input type="checkbox"/> CPK	<input type="checkbox"/> Glucose, Quantitative	<input type="checkbox"/> HIV Screen	<input type="checkbox"/> Phosphatase, Alkaline	<input type="checkbox"/> RPR
<input type="checkbox"/> BNP	<input type="checkbox"/> Creatinine	<input type="checkbox"/> Glutaminyltransferase Gamma	<input type="checkbox"/> Iron/TIBC	<input type="checkbox"/> Phosphorus	<input type="checkbox"/> SGOT (AST)
<input type="checkbox"/> BUN	<input type="checkbox"/> Depakene	<input type="checkbox"/> Lactate Dehydrogenase (LDH)	<input type="checkbox"/> Potassium	<input type="checkbox"/> Protein, Total	<input type="checkbox"/> SGPT (ALT)
<input type="checkbox"/> B12	<input type="checkbox"/> Digoxin (DIG)	<input type="checkbox"/> LDL	<input type="checkbox"/> PSA Screen	<input type="checkbox"/> Sodium	<input type="checkbox"/> Tegretol (Carbamazepine)
<input type="checkbox"/> Calcium, Total	<input type="checkbox"/> Dilantin (Phenytoin)			<input type="checkbox"/> Tetracycline	
<input type="checkbox"/> Carbon Dioxide Content				<input type="checkbox"/> Valproic Acid	

**STANDING ORDER**

**New Request**

**Change to Existing Order**

**STANDING ORDER**

CIRCLE THE FREQUENCY DESIRED AND INDICATE STARTING MONTH. "Q" MEANS "EVERY".

1. Test _____	Reason Ordered _____
Add: Weekly Bi-Weekly Monthly Other	
Q3 Months Q6 Months Q12 Months	Starting Month 1 2 3 4 5 6 7 8 9 10 11 12 D/C
2. Test _____	Reason Ordered _____
Add: Weekly Bi-Weekly Monthly Other	
Q3 Months Q6 Months Q12 Months	Starting Month 1 2 3 4 5 6 7 8 9 10 11 12 D/C
3. Test _____	Reason Ordered _____
Add: Weekly Bi-Weekly Monthly Other	
Q3 Months Q6 Months Q12 Months	Starting Month 1 2 3 4 5 6 7 8 9 10 11 12 D/C

## Advance Beneficiary Notice

Medicare will only pay for services that it determines to be "reasonable and necessary" as defined by section 1862 (a)(1) of Title XVIII of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Additionally, section 1862 (a)(7) states that Medicare will not cover any procedures associated with routine physical checkups (screening procedures). It is likely that, in your case, Medicare may deny payment for the following service(s): **IT IS REQUIRED THAT YOU INDICATE THE RELATED REASON CODE FOR EACH APPLICABLE TEST BELOW.**

Reason Code	ICD-9 for Code 2	
_____	_____	Arsenic
_____	_____	CBC, WBC, Hemogram or other Blood Counts
_____	_____	CEA, CA125, CA19-9, CA27.29, or other Cancer Antigens
_____	_____	Ferritin
_____	_____	Glycohemoglobin (Hgb A1C)
_____	_____	Glucose
_____	_____	HIV
_____	_____	Chemistry Profiles
_____	_____	Lipid Testing (Coronary Risk Profiles, Lipids, Cholesterol, Triglyceride, etc.)
_____	_____	Magnesium
_____	_____	Prostatic Acid Phosphatase
_____	_____	PSA
_____	_____	PT
_____	_____	Rheumatoid Factor
_____	_____	RPR
_____	_____	Syphilis
_____	_____	Thyroid Testing (T3U, T4, T7, TSH)
_____	_____	Urinalysis */Urine Culture (and related sensitivity and/or identification testing)
_____	_____	Other (please specify) _____

Reason Code	Description
1	Screening procedures are non-covered services
2	Medicare Part B may not deem this medically necessary for the listed diagnosis <b>(ICD-9 Required)</b>
3	Medicare Part B usually does not pay for this procedure
4	Medicare Part B may not pay for this procedure because of frequency limits
5	Medicare Part B does not pay for non-FDA approved testing
6	Other (please specify here) _____

\*Medicare will usually pay for a urinalysis; however, a culture may be added after the results from the urinalysis have been reported and Medicare may not pay for the culture and any related testing.

ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES.  
 \*IF CHOL IS ABNORMAL, HDL & LDL WILL BE DONE UNLESS ORDERED OTHERWISE.  
 \*IF URINE LEUCOCYTES AND/OR NITRATES IS POSITIVE, URINE C&S WILL BE DONE UNLESS INSTRUCTED OTHERWISE.  
 \*IF SICKLE CELL POSITIVE HEMOGLOBIN ELECTROPHORESIS WILL BE DONE FOR CONFIRMATION UNLESS INSTRUCTED OTHERWISE.  
 THE TEST ARE GROUPED AS PROFILES TO PERMIT MORE PRECISE DIAGNOSIS OF SPECIFIC CONDITIONS. IF YOU DESIRE INDIVIDUAL TESTS ONLY PLEASE MARK INDIVIDUALLY.  
 IF GLUCOSE IS ELEVATED GLYCOHEMOGLOBIN WILL BE PERFORMED UNLESS INSTRUCTED OTHERWISE.