

Patient Last Name			First			M.I.	I.D. #
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Address			Date Collected	Ordering Physician		
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City			State	Zip	Time Collected	Comments / Additional Tests	
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Phone #	D.O.B.	Age	Sex	STAT	Call Result	Fasting Yes No	
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BILL: <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PATIENT <input type="checkbox"/> INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> F-PACT						Fax To:	
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BILLING INFORMATION			Only medically necessary tests should be ordered when billed to Medicare and Medi-Cal				
Primary Insured			Diagnosis Code(s) (ICD-9) ONLY				
Insurance Company							

Insurance Company Address							
Policy No. & I.D. No.			Group #				

Medicare #			Medi-Cal #				
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SPECIMENS RECEIVED (LAB USE ONLY)								
<input type="checkbox"/> SS	<input type="checkbox"/> G	<input type="checkbox"/> SA	<input type="checkbox"/> FP	<input type="checkbox"/> GR	<input type="checkbox"/> U	<input type="checkbox"/> SW	<input type="checkbox"/> OP	<input type="checkbox"/> TP
<input type="checkbox"/> R	<input type="checkbox"/> LB	<input type="checkbox"/> FS	<input type="checkbox"/> RB	<input type="checkbox"/> SL	<input type="checkbox"/> BD	<input type="checkbox"/> CV	<input type="checkbox"/> BI	<input type="checkbox"/> CP
<input type="checkbox"/> L	<input type="checkbox"/> PK	<input type="checkbox"/> PL	<input type="checkbox"/> Y	<input type="checkbox"/> FF	<input type="checkbox"/> M4	<input type="checkbox"/> ST	<input type="checkbox"/> 24	<input type="checkbox"/> SU

AMA APPROVED PANELS			MICROBIOLOGY (#-CULTURE W/ SENS. IF INDICATED) SOURCE: _____ (CULTURE)				
Acute Hepatitis Panel SS			<input type="checkbox"/> Cervical Culture# <input type="checkbox"/> Herpes Culture (ELVIS) <input type="checkbox"/> Stool Culture# <input type="checkbox"/> Chlamydia PCR <input type="checkbox"/> Myco / Ureaplasma <input type="checkbox"/> Throat Beta Strep A <input type="checkbox"/> Chlamydia TMA (Aptima®/Gen-Probe®) <input type="checkbox"/> Nasal Culture# <input type="checkbox"/> Urine Culture# <input type="checkbox"/> GBS Screen <input type="checkbox"/> Occult Blood <input type="checkbox"/> Vaginal Culture-No GBS# <input type="checkbox"/> Gonorrhea PCR <input type="checkbox"/> Ova & Parasites <input type="checkbox"/> Vaginal Culture - with GBS# <input type="checkbox"/> Gonorrhea TMA (Aptima®/Gen-Probe®) <input type="checkbox"/> Routine Culture <input type="checkbox"/> Wound Culture <input type="checkbox"/> Gram Stain <input type="checkbox"/> Sputum Culture# <input type="checkbox"/> _____				
Basic Metabolic Panel G, SS			Hepatic Function Panel SS				
Comp. Metabolic Panel G, SS			Lipid Panel SS				
Electrolyte Panel SS			Prenatal Panel L, PK, SS				
General Health Panel G, L, SS			Renal Function Panel G, SS				

TESTS									
<input type="checkbox"/> 17 OH Progesterone R or L <input type="checkbox"/> Alkaline Phosphatase SS <input type="checkbox"/> Amylase SS <input type="checkbox"/> ANA (EIA) SS <input type="checkbox"/> Antibody Screen PK <input type="checkbox"/> Anti-Cardiolipin IgA SS <input type="checkbox"/> Anti-Cardiolipin IgG SS <input type="checkbox"/> Anti-Cardiolipin IgM SS <input type="checkbox"/> Bilirubin Total SS <input type="checkbox"/> Blood Group & Rh Type PK <input type="checkbox"/> Brain Natriuretic Peptide (BNP) L <input type="checkbox"/> BUN SS <input type="checkbox"/> CA 15-3* SS <input type="checkbox"/> CA 19-9* SS <input type="checkbox"/> CA 125* SS <input type="checkbox"/> Calcium SS		<input type="checkbox"/> CBC w/ Diff* L <input type="checkbox"/> CEA* SS <input type="checkbox"/> Cholesterol* SS <input type="checkbox"/> CMV IgG SS <input type="checkbox"/> CMV IgM SS <input type="checkbox"/> CMV Total FK or L <input type="checkbox"/> C-Peptide R or L <input type="checkbox"/> CPK SS <input type="checkbox"/> Creatinine SS <input type="checkbox"/> C-Reactive Protein (CRP) HS SS <input type="checkbox"/> DHEA SS <input type="checkbox"/> DHEA Sulfate SS <input type="checkbox"/> Digoxin* R <input type="checkbox"/> Dilantin R <input type="checkbox"/> EBV IgG SS <input type="checkbox"/> EBV IgM SS		<input type="checkbox"/> Estradiol SS <input type="checkbox"/> Ferritin* SS <input type="checkbox"/> Fetal Fibronectin SPECIAL SW <input type="checkbox"/> Fibrinogen LB <input type="checkbox"/> Folic Acid SS <input type="checkbox"/> FSH SS <input type="checkbox"/> GGTP* SS <input type="checkbox"/> Glucose, Fasting* G <input type="checkbox"/> Glucose, Gest. ___HR(s) G <input type="checkbox"/> Glucose, Post Prand. ___HR G <input type="checkbox"/> Glycohemoglobin* L <input type="checkbox"/> H. Pylori, IgG SS <input type="checkbox"/> HCG Quant* SS <input type="checkbox"/> Hemoglobin Electrophoresis L <input type="checkbox"/> Hepatitis A Ab, Total* SS <input type="checkbox"/> Hepatitis A Ab, IgM SS <input type="checkbox"/> Hepatitis B Core, IgM* SS <input type="checkbox"/> Hepatitis B Core Ab, Total* SS <input type="checkbox"/> Hepatitis B Surface Ab* SS <input type="checkbox"/> Hepatitis B Surface Ag* SS <input type="checkbox"/> Hepatitis C Antibody* SS <input type="checkbox"/> Hepatitis C RNA by PCR, Qual* L <input type="checkbox"/> Herpes 1 IgG (HerpeSelect TM) SS <input type="checkbox"/> Herpes 2 IgG (HerpeSelect TM) SS <input type="checkbox"/> Herpes 1 IgM SS		<input type="checkbox"/> Herpes 2 IgM SS <input type="checkbox"/> HIV-1&2 Plus O Ab Screen SS <input type="checkbox"/> Homocysteine SS <input type="checkbox"/> Insulin (Serum) SS <input type="checkbox"/> Iron* SS <input type="checkbox"/> Iron & TIBC* SS <input type="checkbox"/> LDH SS <input type="checkbox"/> LH SS <input type="checkbox"/> Lipase SS <input type="checkbox"/> Lipoprotein (a) SS <input type="checkbox"/> Lupus Anticoagulant Screen LB <input type="checkbox"/> Magnesium* SS <input type="checkbox"/> Mono Screen SS <input type="checkbox"/> Potassium SS <input type="checkbox"/> Progesterone SS <input type="checkbox"/> Prolactin SS <input type="checkbox"/> Protein, Urine U <input type="checkbox"/> PSA, Free* SS <input type="checkbox"/> PSA, Total* SS <input type="checkbox"/> PTH 1-84, Intact w/Calcium SS <input type="checkbox"/> PT (Prothrombin Time)* LB <input type="checkbox"/> PTT (Activated)* LB <input type="checkbox"/> RA Factor SS <input type="checkbox"/> RPR*w/reflex to FTA SS <input type="checkbox"/> Rubella, IgG SS		<input type="checkbox"/> Sedimentation Rate (ESR)* L <input type="checkbox"/> SGPT (ALT) SS <input type="checkbox"/> SGOT (AST) SS <input type="checkbox"/> T3 Free SS <input type="checkbox"/> T3 Total* SS <input type="checkbox"/> T3 Uptake* SS <input type="checkbox"/> T4 (Thyroxine) Total* SS <input type="checkbox"/> T4 Free * SS <input type="checkbox"/> Testosterone Free R or SS <input type="checkbox"/> Testosterone Total SS <input type="checkbox"/> Thyroglobulin Ab SS <input type="checkbox"/> Thyroid Peroxidase Ab SS <input type="checkbox"/> Toxoplasma IgG SS <input type="checkbox"/> Toxoplasma IgM SS <input type="checkbox"/> Triglycerides* SS <input type="checkbox"/> TSH* SS <input type="checkbox"/> Uric Acid SS <input type="checkbox"/> Urinalysis w/microscopic U <input type="checkbox"/> Urinalysis (dipstick ONLY) U <input type="checkbox"/> Urinalysis w/reflex, if indicated U <input type="checkbox"/> Urine Drug Screen U <input type="checkbox"/> Varicella Zoster IgG SS <input type="checkbox"/> Vitamin B12 SS <input type="checkbox"/> Vitamin D 25-Hydroxy SS	

PATIENT SIGNATURE:	
Draw Fee [DRAW]	

CYTOPATHOLOGY / HISTOPATHOLOGY			
PAP SMEARS		HPV AND 16/18 GENOTYPING	
<input type="checkbox"/> ThinPrep® Pap (with Imager) <input type="checkbox"/> ThinPrep® Pap (no Imager) <input type="checkbox"/> SurePath® Pap <input type="checkbox"/> ThinPrep® or SurePath® + HPV HR <input type="checkbox"/> Conventional Pap		<input type="checkbox"/> HPV HR (Cervista®) <input type="checkbox"/> HPV HR (Cervista®) if ASC-US <input type="checkbox"/> 16/18 Genotyping if HPV HR is Detected (Cervista®)	
		CHLAMYDIA/GONORRHEA/URINE CYTO	
		<input type="checkbox"/> Chlamydia PCR <input type="checkbox"/> Gonorrhea PCR <input type="checkbox"/> Chlamydia TMA (Aptima®/Gen-Probe®) <input type="checkbox"/> Gonorrhea TMA (Aptima®/Gen-Probe®) <input type="checkbox"/> Urine Cytology	
Source: [] CERVIX [] ENDO [] VAG [] C/V/E [] OTHER: _____			
<input type="checkbox"/> Biopsy List Site(s) 1. _____ 2. _____ 3. _____ 4. _____		<input type="checkbox"/> Products Of Conception <input type="checkbox"/> TAB	

CLINICAL INFO		LMP: / /		HISTORY		STATUS	
<input type="checkbox"/> Routine / Annual Pap <input type="checkbox"/> Pregnant <input type="checkbox"/> Post-Partum <input type="checkbox"/> Abortion		<input type="checkbox"/> Contraceptives <input type="checkbox"/> IUD <input type="checkbox"/> Depo-provera <input type="checkbox"/> Other: _____		<input type="checkbox"/> Postmenopausal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Partial Hyst. (Pt has cervix) <input type="checkbox"/> Abnormal Bleeding		<input type="checkbox"/> Chemo Rx <input type="checkbox"/> Hormone Rx <input type="checkbox"/> Radiation Rx <input type="checkbox"/> Oophorectomy	

ACUTE HEPATITIS PANEL

(CPT 80074)
Hepatitis A Antibody (HAAb) IgM
Hepatitis B Core Antibody (HbcAb) IgM
Hepatitis B Surface Antigen (HbsAg)
Hepatitis C Antibody (HCAb)

COMPREHENSIVE METABOLIC PANEL

(CPT 80053)
Albumin
Bilirubin, total
Calcium
Carbon dioxide (bicarbonate)
Chloride
Creatinine
Glucose
Phosphatase, alkaline
Potassium
Protein, total
Sodium
Transferase alanine amino (ALT) (SGPT)
Transferase aspartate amino (AST) (SGOT)
Urea nitrogen (BUN)

GENERAL HEALTH PANEL

(CPT 80050)
Albumin
Bilirubin, total
Calcium
Carbon dioxide (bicarbonate)
CBC + Diff.
Chloride
Creatinine
Glucose
Phosphatase, alkaline
Potassium
Protein, total
Sodium
Transferase alanine amino (ALT) (SGPT)
Transferase aspartate amino (AST) (SGOT)
TSH, Hypersensitive
Urea Nitrogen (BUN)

LIPID PANEL

(CPT 80061)
Cholesterol, total
Cholesterol/HDL, Ratio
HDL, cholesterol
LDL, cholesterol
Triglycerides
VLDL

BASIC METABOLIC PANEL (CALCIUM, TOTAL)

(CPT 80048)
Calcium, total
Carbon dioxide
Chloride
Creatinine
Glucose
Potassium
Sodium
Urea nitrogen (BUN)

ELECTROLYTE PANEL

(CPT 80051)
Carbon dioxide (CO2)
Chloride
Potassium
Sodium

HEPATIC FUNCTION PANEL

(CPT 80076)
Albumin
Bilirubin, direct
Bilirubin, total
Phosphatase, alkaline
Protein, total
Transferase alanine amino (ALT) (SGPT)
Transferase aspartate amino (AST) (SGOT)

RENAL FUNCTION PANEL

(CPT 80069)
Albumin
Calcium
Carbon dioxide (bicarbonate)
Chloride
Creatinine
Glucose
Phosphorus, inorganic (phosphate)
Potassium
Sodium
Urea nitrogen (BUN)

BASIC METABOLIC PANEL (CALCIUM, IONIZED)

(CPT 80047)
Calcium Ionized
Carbon dioxide
Chloride
Creatinine
Glucose
Potassium
Sodium
Urea nitrogen (BUN)

Patient's Name:

Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informal choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimated Cost: \$ _____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX, SIGN & DATE YOUR CHOICE.

Option 1. YES. I want to receive these laboratory tests.

I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these laboratory tests.

I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.