



**BILL TO:**  
 PATIENT  
 MEDICARE  
 RAILROAD MEDICARE  
 Medi-Cal  
 Lab Card/Select  
 OTHER INSURANCE

PRINT PATIENT NAME (LAST, FIRST, MIDDLE) \_\_\_\_\_

PATIENT ID / REGISTRATION # \_\_\_\_\_ DATE OF BIRTH M M D D YEAR \_\_\_\_\_ SEX \_\_\_\_\_

ROOM # \_\_\_\_\_ LAB REFERENCE # \_\_\_\_\_

PATIENT SOCIAL SECURITY # \_\_\_\_\_ PATIENT PHONE # ( ) \_\_\_\_\_

PATIENT STREET ADDRESS \_\_\_\_\_ APT. # \_\_\_\_\_ KEY # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT \_\_\_\_\_

INSURED ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

RELATIONSHIP TO INSURED  SELF  SPOUSE  DEPENDENT

INSURANCE COMPANY NAME / IPA NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE ID # \_\_\_\_\_ GROUP # / DATE OF INJURY \_\_\_\_\_

MEDICARE # \_\_\_\_\_ MEDICAL # \_\_\_\_\_

EMPLOYER NAME / EMPLOYER # \_\_\_\_\_

**DID YOU KNOW**

**Patient Service Center location and appointment scheduling information is on the back.**

**Each sample should be labeled with at least two patient identifiers at time of collection.**

DATE COLLECTED \_\_\_\_\_ TIME  AM  PM TOTAL VOL./HRS. \_\_\_\_\_ ML \_\_\_\_\_ HR \_\_\_\_\_  Fasting  Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

ADDIT'L PHYS.: Dr. \_\_\_\_\_ NPI/UPIN \_\_\_\_\_

NON-PHYSICIAN PROVIDER: NAME \_\_\_\_\_ I.D.# \_\_\_\_\_

Fax Results to: ( ) \_\_\_\_\_

Client # OR NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE COMPANY NAME / IPA NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE ID # \_\_\_\_\_ GROUP # / DATE OF INJURY \_\_\_\_\_

MEDICARE # \_\_\_\_\_ MEDICAL # \_\_\_\_\_

EMPLOYER NAME / EMPLOYER # \_\_\_\_\_

Medicare Limited Coverage Tests

@ = May not be covered for the reported diagnosis.  
 F = Has prescribed frequency rules for coverage.  
 & = A test or service performed with research/experimental kit.  
 B = Has both diagnosis and frequency-related coverage limitations.

**ICD Codes (enter all that apply)**

Provide signed ABN when necessary

Check Box	Test Code	Description	Check Box	Test Code	Description	Check Box	Test Code	Description
	10611	Anaplasma \$240		1777	Protein C Activ FZ PL \$27.00		34271	Ehrlichia ABS (S) RFGD \$40.00
	10231	CMP, Serum \$23.96		1779	Protein S Activ FZ PL \$30.00		7197	Lymph Subset Panel 1 \$75.46
	6399	CBC \$15.20		4914	PT & PTT, LT BL RM T \$19.50		34184	Natural Killer Activity \$121.50
	561	Insulin, Serum RFGD \$22.50		17306	VitD 25 (S) PI RedRM T \$75.50		11345	Thrombotic PN 3Aliquots 2ml FZ PLBL \$72.02
	10124	Cardio CRP, (S) RFGD \$25.00		CP313388	Fungal Pnl (S) RmT M-F \$88.16		8659	D-Dimer FZ PL \$15.85
	7573	Iron & Total Iron Bind(S) \$28.78		457	Feritin \$30.00		29851	Serotonin FRZ (S) \$60.75
	467	Folate RBC, Lav, RmT \$33.70		37914	Eosinophil Catonic Prot. \$50.00		29477	Lyme WB \$73.79
	927	B12, PI Red, RFGD \$35.00		34458	IGFBP-3 \$35.00		93166	PAI - 1 ANTIGEN FRZ PL BL \$28.50
	30289	E2 Ultrasens(S) RedFZ \$55.97		683	ACE, (S) RFGD \$28.55		34883	Estriol (S) PL Red FRZ \$40.55
	623	Magnesium RBC Lav RFGD \$13.10		5363	PSA Total (S) Frz \$61.68		15447	EBV EarlyAGD ABIGM 1ML(S) \$26.39
	461	Fibrinogen BL RmT \$25.00		4021	Estradiol (S) RFGD \$40.55		19956	C4 (A) 1ml FRZ PL(EDTA) 111.00
	34604	Lipo (a) PLRed Refrig \$25.00		470	FSH, Plain Red \$35.00		16842	Anti-Mullerian Hormone \$63.00
				615	LH, (S) \$35.00		CP341651	Toxic Mold Panel \$144.91
X	899	TSH 3 <sup>rd</sup> Gen, (S) \$30.00		745	Progesterone (S) RFGD \$35.00	X	90367	Leptin (S) PL Red RFGD \$45.00
X	866	T4, Free (S) RFGD \$25.00		7083	Immunoglobulins-QT 3ml(S) \$54.00		34300	Babsia MicrotiAB IGG/M IFA \$48.50
X	34429	T3 Free(S) RFGD \$35.00		7903	IGGSubclasses2ml(S)RFGD\$81.00		11368	PAI-14G/5G 5ML Whole BL Lav RmT\$84.00
X	90963	Reverse T3 (S) RFGD \$32.21		17408	C-Telopeptide FZ(S)Red\$21.25	X	16599	Iodine dark blue
X	5081	Thyroid PeroxAB (S)RFGD\$28.50		90567	DHT (S) RFGD \$35.88		30551	Thyroid stim lmg (S)
X	267	ThyroglobulinAB(S)RFGD\$30.00		211	ACTH FZ Plasma Lav \$75.00		17133	Selenium EDTA
	7600	Lipid panel (S) RFGD \$30.68		CP334578	Allergy Panel \$35.77			
	31789	Homocysteine (S) RFGD \$50.00		15447	EB-V EA-D AB(S) FZ M-F \$35.49			
	37077	Cortisol F&T (S) RFGD\$64.75		6732	CMV IGG/IGM (S)RFGD\$58.15			
	8181	Hemoglobin A1C, LAV \$19.00		34282	HHV6 FZ (S) \$50.40			
	23244	Estrone PLRed Frz (S) \$49.00		37126	ChlamydiaPneum(S) Ref\$58.85			
	402	DHEA-S (S) RFGD \$40.00		34127	MycoplasmalGG/M (S) \$54.15			
	31493	Pregnenolone (S)RFGD\$40.00		30440	Candida IGG/M/A (S) RFGD\$80.0			
	36170	Testosterone F&T (S)PL R \$138.03		14512	VEGF \$25.50			
	839	IGF-1 FRZ PL RED (S) \$38.50		34251	Bartonella IGG/M RFL \$318.24			
X	30740	SHGB (S) RFGD \$38.50		15435	Immune Cell Function \$152.07			
	91238	Human Growth Factor Beta 1\$70		37478	Ricketts AB PNL2 w/RFX\$214.64			