





OUTPATIENT/SPECIMEN LABORATORY ORDER FORM - A

- Bill Patient or Insurance
Bill Client Account
Bill Medicare

PHYSICIAN OFFICE: Call Centralized Scheduling (217) 757-6565 or send signed form with patient or FAX to (217) 757-6874. To contact the lab call (217) 544-6464, ext. 44185 or FAX to (217) 535-3775.

HHS

PLEASE PRINT

Shaded tests may require ABN signed by Medicare patients.

Tech. Code:

Form with fields for Patient last name, First name, Middle initial, Date of birth, Sex, Employer, Medical record number, Social Security #, Collection date, Collection time, Telephone (home), Physician, Consulting physician, Patient address, City, State, Zip, Guarantor name, Address, City, State, Zip, Carrier, Carrier address, City, State, Zip, Name of insured, Policy number, Group number, Medicare number, Medicaid number, Year of retirement.

Table with columns: Test Description, CPT Code, ICD10 Diagnosis. Rows include Pre-Eclampsia Tests, 24 HOUR URINE TESTS, Hematology/Coagulation Tests, Obstetrics Panel, Arthritis Tests, Iron Tests.

\* Denotes tests which may reflex to additional tests. Refer to Laboratory Protocol Order Document.

When ordering laboratory testing for which Medicare reimbursement will be sought, physicians (or other authorized individuals) should order only those tests that are considered medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

Dx/symptom ICD10-CM Code 1 2 3 4
Call results YES NO Date/Time: M.D.

PHYSICIAN SIGNATURE REQUIRED

