HSHS St. John's Hospital

# OUTPATIENT/SPECIMAN LABORATORY ORDER FORM − B

❑ 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 Tech. Code:_____

**PLEASE PRINT** *Shaded tests may require ABN signed by Medicare patients.*

| | | | | |
|---|---|---|---|---|
| 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 | | |

| Test Description | CPT Code | ICD10 Diagnosis |
|---|---|---|
| * ☐ **Acute Hepatitis Panel** | **80074** | |
| * ☐ Hepatitis B surface antigen (HBsAG) | 87340 | |
| * ☐ Hepatitus B core antibody (HBcAB−IgM) | 86705 | |
| * ☐ Hepatitus a antibody (HAAb−IgM) | 86709 | |
| * ☐ Hepatitis C antibody | 86803 | |
| **MICROBIOLOBY/VIROLOGY** | | |
| * ☐ **Culture, Uhrine** | **87086** | |
| * ☐ **Culture, Feces** | **87045** | |
| * ☐ **Culture, Wound** | **87070** | |
| * ☐ **Culture, _____** | | |
| * ☐ **Throat culture (all organisms)** | **87070** | |
| ☐ **Throat culture (no beta strep screen)** | **87081** | |
| * ☐ **Throat culture (w/beta strep screen)** | **87081** | |
| ☐ **Sensitivity** | **87184** | |
| ☐ **Ova & parasites** | **87177** | |
| ☐ **Clostridium Diff Toxin** | **87324** | |
| ☐ **PCR for Chlamydia & GC** | **87591 & 87491** | |
| ☐ **PCR for Chlamydia only** | **87491** | |
| ☐ **PCR for N gonorrhoeae only** | **87591** | |
| ☐ **Pinworm direct exam** | **87172** | |
| ☐ **Wet prep for Trichomonas** | **87210** | |
| ☐ **Gram stain (bacteria, clue cells or BV, yeast)** | **87205** | |
| ☐ **KOH prep (only skin, hair & nails** | **87220** | |

| Test Description | CPT Code | ICD10 Diagnosis |
|---|---|---|
| ☐ **Prenatal strep B screen** | **87081** | |
| ☐ **Fecal luekocytes** | **89055** | |
| ☐ **Herpes cultures** | **87252** | |
| **INDIVIDUAL TESTS** | | |
| ☐ **Amylase** | **82150** | |
| ☐ **CA 125** | **86304** | |
| ☐ **CA27.29** | **86136** | |
| ☐ **Carbamazepine (Tegretol)** | **80156** | |
| ☐ **CEA** | **82378** | |
| ☐ **Cortisol** | **82533** | |
| ☐ **CK** | **82550** | |
| ☐ **CK−MB** | **82553** | |
| ☐ **Depakane (Valproic Acid)** | **80164** | |
| ☐ **Digoxin** | **80162** | |
| ☐ **Dilantin (Phenytoin)** | **80185** | |
| ☐ **Estradiol** | **82670** | |
| ☐ **FSH** | **83001** | |
| ☐ **Fungal serology** | **86329** | |
| ☐ **Glucose (Fasting)** | **82947** | |
| ☐ **Glycosylated hemoglobin** | **83036** | |
| ☐ **IgE** | **82785** | |
| ☐ **Imipramine (Fractionated)** | **80174** | |
| ☐ **Immunoglobulin (IgG, IgM, IgA − each)** | **86784** | |
| ☐ **Lead (include state lead form)** | **83655** | |
| ☐ **LH** | **83002** | |

*** 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. Any physician who orders a test which may be determined to be medically unnecessary by the government may be subject to civil penalties as determined by that government agency. Appropriate ICD−9 diagnosis coding must be provided to document the necessity of laboratory testing requested.

**Dx/symptom ICD10−CM Code 1**_____ **2**_____ **3**_____ **4**_____

**Call results** ❑ YES ❑ NO **Date/Time**_____ **Physician Signature**_____**M.D. (required)**

**A7489−B**
**Rev. 12/15/15**



**Call results** ☐ **YES** ☐ **NO** **Date/Time:** _____ _____ **M.D.**
***PHYSICIAN SIGNATURE REQUIRED***

HSHS St. John's Hospital

# OUTPATIENT/SPECIMAN LABORATORY ORDER FORM − B

**PLEASE PRINT** *Shaded tests may require ABN signed by Medicare patients.* Tech. Code:_____

| | | | | |
|---|---|---|---|---|
| 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 | | |

| | Test Description | CPT Code | ICD10 Diagnosis |
|---|---|---|---|
| ☐ | Lithium | 80178 | _____ |
| ☐ | Lipase | 83690 | _____ |
| ☐ | Magnesium | 83735 | _____ |
| ☐ | Measles (IgG) | 86765 | _____ |
| ☐ | Microalbumin | 82043 | _____ |
| ☐ | Phenobarbitol | 80184 | _____ |
| ☐ | Phosphorus | 84100 | _____ |
| ☐ | Progesterone | 84144 | _____ |
| ☐ | Prolactin | 84146 | _____ |
| ☐ | Protein Electrophoresis | 84165 | _____ |
| * ☐ | PSA Diagnostic | 84153 | _____ |
| ☐ | PSA Screen | G0103 | _____ |
| ☐ | PTH intact molecule | 83970 | _____ |
| ☐ | Rubella screen IgG) | 86762 | _____ |
| ☐ | Testosterone | 84403 | _____ |
| ☐ | Theophylline | 80198 | _____ |
| ☐ | Tricyclic Antidepressant (Total) | 80229 | _____ |
| ☐ | Troponin T | 84484 | _____ |
| ☐ | Vancomycin | 80202 | _____ |

| | Test Description | CPT Code | ICD10 Diagnosis |
|---|---|---|---|
| | **TRANSFUSION SERVICE** | | |
| ☐ | ABO and RH | 86900 | _____ |
| * ☐ | Antibody screen | 86850 | _____ |
| * ☐ | Rh Immune globulin | 86999 | _____ |
| ☐ | Antibody titer | 86886 | _____ |
| ☐ | Fetal−maternal hemorrhage quantitation | 85461 | _____ |
| ☐ | Type and screen only | | _____ |
| * ☐ | Type & crossmatch for _____ units | | _____ |
| | To be given ____/____/____ | | |
| | For surgery on ____/____/_____ | | |
| | Component type:_____ | | |
| ☐ | Transfuse_____ units of platelets | | _____ |
| | ☐ Random donor or ☐ selected donor | | |
| | ☐ Leuko−poor platelets | | |
| | ☐ Leuko−poor irradiated platelets | | |
| ☐ | Other | | _____ |
| ☐ | Other | | _____ |
| ☐ | Other | | _____ |
| ☐ | Other | | _____ |
| ☐ | Other | | _____ |
| ☐ | Other | | _____ |
| ☐ | Other | | _____ |

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

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**Dx/symptom ICD10−CM Code 1**_____ **2**_____ **3**_____ **4**_____

**Call results** ☐ **YES** ☐ **NO** **Date/Time:** _____ _____ **M.D.**

***PHYSICIAN SIGNATURE REQUIRED***

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OEYOUTPT