AVERO™

SURGICAL PATHOLOGY / CYTOLOGY REQUISTION

Client Services: 1-866-987-7284

SP088001

PATIENT INFORMATION

Patient Name (Last, First, M.I.)

SSN | DOB | Sex | Race

Address

City | State | Zip

PHYSICIAN INFORMATION

Physician Signature (required):

SPECIMEN INFO: **Date Collected (MM/DD/YY)** **Time Collected** ☐ AM ☐ PM

Other Physician To Receive Reports:

SPECIMENS

Specimen A_____

Specimen B_____

Specimen C_____

Specimen D_____

Specimen E_____

Specimen F_____

HISTORY / DIAGNOSTIC INFORMATION (ICD-10)

PATIENT INSURANCE INFORMATION.

PLEASE PROVIDE COPY OF INSURANCE CARD OR COMPLETE INFORMATION BELOW.

ATTACH A COPY OF THE PATIENT'S INSURANCE CARD

AND YOUR REGISTRATION INFORMATION IF APPLICABLE

Bill to: ❑ Medicare ❑ Insurance ❑ Patient

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY	COMPANY
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
PHONE	PHONE
POLICY / ID NUMBER	POLICY / ID NUMBER
GROUP NUMBER	GROUP NUMBER
NAME OF POLICYHOLDER	NAME OF POLICYHOLDER

Physician Notice – Medicare will only pay for medical necessity testing supported with a symptomatic diagnosis. Medicare patients should sign the Advance Beneficiary Notice of Noncoverage (ABN) on the back of the requisition.

1. Complete the requisition with all requested information. 2. Clearly print the patient name on the label (do not write on the bar code)
3. Place one label on each specimen container(not the lid)

SP088001 Specimen A:_____ Name_____	SP088001 Specimen F:_____ Name_____	SP088001 Specimen K:_____ Name_____	SP088001 Specimen P:_____ Name_____
SP088001 Specimen B:_____ Name_____	SP088001 Specimen G:_____ Name_____	SP088001 Specimen L:_____ Name_____	SP088001 Specimen Q:_____ Name_____
SP088001 Specimen C:_____ Name_____	SP088001 Specimen H:_____ Name_____	SP088001 Specimen M:_____ Name_____	SP088001 Specimen R:_____ Name_____
SP088001 Specimen D:_____ Name_____	SP088001 Specimen I:_____ Name_____	SP088001 Specimen N:_____ Name_____	SP088001 Specimen S:_____ Name_____
SP088001 Specimen E:_____ Name_____	SP088001 Specimen J:_____ Name_____	SP088001 Specimen O:_____ Name_____	SP088001 Specimen T:_____ Name_____

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Dallas Laboratory: 6221 Riverside Drive, Suite 119, Irving, TX 75039
Lubbock Laboratory: 410 North Utica Avenue, Lubbock, TX 79416
www.averodx.com • 877-232-9924

Notifier:

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **laboratory tests** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **laboratory tests** below.

Laboratory Tests	Reason Medicare May Not Pay:	Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **laboratory tests** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **laboratory tests** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **laboratory tests** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **laboratory tests** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

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