



# CLINICAL REQUISITION

PATIENT INFORMATION		CLINICIAN INFORMATION	
LAST NAME		<div>ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the test(s) requested herein.</div> <div>REQUIRED  ORDERING CLINICIAN SIGNATURE DATE (MM/DD/YY)</div> <div>BILLING INFO</div> <div><input type="checkbox"/> BILL INSURANCE Attach legible front and back copy of insurance cards.</div> <div>INSURANCE COMPANY</div> <div>IPA NAME</div> <div>MEMBER ID</div> <div><input type="checkbox"/> BILL PATIENT Patient will be contacted to provide payment method.</div> <div><input type="checkbox"/> CLIENT BILL</div>	
FIRST NAME			
MIDDLE NAME			
DATE OF BIRTH (MM/DD/YYYY)			
PATIENT MRN			
TELEPHONE NUMBER			
SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other/Unknown			
STREET NUMBER			
STREET NAME			
APT NUMBER			
CITY			
STATE			
ZIP			
<div>ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I may be responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim.</div> <div>PATIENT SIGNATURE DATE (MM/DD/YY)</div> <div>X</div>			
SPECIMEN INFORMATION - REQUIRED			
Collected on: Fasting: HRS			
Time: AM PM Urine hrs/vol: HRS VOL			
DIAGNOSTIC INFORMATION (ICD-10)			
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.			

TEST OPTIONS							
CHEMISTRY TESTING	CODE	HEMATOLOGY & COAG TESTING	CODE	ALLERGY TESTING	CODE	MICROBIOLOGY	
<input type="checkbox"/> * Basic Metabolic Panel	CHP0002 SST	<input type="checkbox"/> * CBC w/ Auto Diff, Rflx to Manual Diff	HMP0001 LAV	<input type="checkbox"/> Cat Component Panel	ALP0005 SST	<b>Wound Culture &amp; Sensitivity, w/ Gram Stain</b>	
<input type="checkbox"/> * Comprehensive Metabolic Panel	CHP0001 SST	<input type="checkbox"/> * CBC w/ No Diff	HMP0003 LAV	<input type="checkbox"/> Dog Component Panel	ALP0006 SST	<input type="checkbox"/> Aerobic Culture	M_WOUND
<input type="checkbox"/> * Electrolyte Panel, Serum	CHP0008 SST	<input type="checkbox"/> * CBC, Auto Diff w/ Anemia Reflex	HMP0001-A S	<input type="checkbox"/> E. Cascadia Region Respiratory Allergens	ALP0041 SST	<input type="checkbox"/> Aerobic & Anaerobic Culture	M_AER_ANER
<input type="checkbox"/> * Hepatic Function Panel	CHP0005 SST	<input type="checkbox"/> * Factor II&V (Leiden) PCR (Qualitative)	MIP0002 LAV	<input type="checkbox"/> Early Childhood Allergen Profile	ALP0001 SST	Site: _____	
<input type="checkbox"/> * Iron and Iron Binding Capacity	CHP0013 SST	<input type="checkbox"/> ESR	HM000138 LAV	<input type="checkbox"/> Egg Component Panel	ALP00013 SST	Source: _____	
<input type="checkbox"/> * Lipid Panel w/ Calculated LDL	CHP0003 SST	<input type="checkbox"/> Hemoglobin & Hematocrit	HMP0006 LAV	<input type="checkbox"/> Food Allergen Profile	ALP0002 SST	<b>Fungal/Yeast Testing</b>	
<input type="checkbox"/> * Lipid Panel w/ Rflx to Direct LDL	CHP0016 SST	<input type="checkbox"/> Platelet Count	HM000107 LAV	<input type="checkbox"/> Food Allergen Profile, Rflx to Components	ALP0043 SST	<input type="checkbox"/> Fungal Culture & CFW Stain	M_FUNGAL
<input type="checkbox"/> * Renal Function Panel	CHP0011 SST	<input type="checkbox"/> Reticulocyte Count	HMP0010 LAV	<input type="checkbox"/> Fruit Profile (Allergen)	ALP0032 SST	<input type="checkbox"/> Yeast Culture Only	M_YEAST
<input type="checkbox"/> Albumin	CH000004 SST	<input type="checkbox"/> aPTT	C0000201 B	<input type="checkbox"/> Gluten Profile (Allergen)	ALP0040 SST	<b>Enteric Testing</b>	
<input type="checkbox"/> Albumin/Creatinine Ratio, Urine	UN000108 SST	<input type="checkbox"/> Fibrinogen Activity	C0000301 B	<input type="checkbox"/> Legume Profile (Allergen)	ALP0034 SST	<input type="checkbox"/> Calprotectin, Fecal	LC-123255
<input type="checkbox"/> Alk Phos	CH000005 SST	<input type="checkbox"/> PT/INR	C0000101 B	<input type="checkbox"/> Meat Profile (a-Gal, Beef, Mutton, Pork, Chicken)	ALP00027 SST	<input type="checkbox"/> C. Difficile, Stool	MI000100
<input type="checkbox"/> ALT (SGPT)	CH000003 SST	<b>THYROID &amp; AUTOIMMUNE TESTING</b>		<input type="checkbox"/> Milk Component Panel	ALP00017 SST	<input type="checkbox"/> GI Pathogen Panel, Stool	MIP0004
<input type="checkbox"/> Amylase	CH000007 SST	<input type="checkbox"/> * ANA Diagnostic Panel	AMP00020 SST	<input type="checkbox"/> Mold Allergy Panel	ALP00029 SST	<input type="checkbox"/> H. Pylori Antigen, Stool	LC-180764
<input type="checkbox"/> AST (SGOT)	CH000009 SST	<input type="checkbox"/> * ANA Screen w/ Reflex	AMP0002 SST	<input type="checkbox"/> Northwest Region Respiratory Allergens	ALP0003 SST	<input type="checkbox"/> Ova & Parasites Exam, Stool	08623
<input type="checkbox"/> Bilirubin, Direct	CH000011 SST	<input type="checkbox"/> * ANCA Profile	AMP0001 SST	<input type="checkbox"/> Shrimp Component Panel	ALP00022 SST	<input type="checkbox"/> Stool Culture	M_STOOL
<input type="checkbox"/> Bilirubin, Total	CH000012 SST	<input type="checkbox"/> * Celiac Disease Panel	AMP0006 SST	<input type="checkbox"/> Soy Component Panel	ALP00023 SST	<input type="checkbox"/> Giardia lamblia Ag, EIA	LC-182204
<input type="checkbox"/> BNP, NT-pro	CH000065 SST	<input type="checkbox"/> * Thyroid Antibodies Panel	AMP0005 SST	<input type="checkbox"/> Texas/Oklahoma Allergens	ALP0044 SST	<b>Respiratory Testing</b>	
<input type="checkbox"/> Calcium	CH000016 SST	<input type="checkbox"/> * Thyroid Function Panel w/ TSH	CHP0012 SST	<input type="checkbox"/> Vegetable-Root/Fruit Profile (Allergen)	ALP0039 SST	<input type="checkbox"/> Respiratory Panel w/Sars (PCR)	MIP0010
<input type="checkbox"/> Chloride	CH000024 SST	<input type="checkbox"/> Anti-Thyroglobulin	AM000030 SST	<input type="checkbox"/> Vegetable-Leaf Profile (Allergen)	ALP0038 SST	<input type="checkbox"/> Sputum, C&S w/ Gram Stain	M_SPUTUM
<input type="checkbox"/> CK	CH000030 SST	<input type="checkbox"/> Anti-TPO	AM000031 SST	<input type="checkbox"/> IgE, Total	AL000536 SST	<input type="checkbox"/> Strep A w/ reflex to Culture (RT-PCR)	MI000101
<input type="checkbox"/> Coritsol	CH000028 SST	<input type="checkbox"/> T3, Free	CH000061 SST	<input type="checkbox"/> IgE - Specify Allergen(s): _____	SST	<input type="checkbox"/> Throat Culture	M_THROAT
<input type="checkbox"/> C-Peptide	CH000013 SST	<input type="checkbox"/> T3, Reverse	LC-070104 SST	<b>INFECTIOUS DISEASE TESTING</b>		<b>Other Micro Testing</b>	
<input type="checkbox"/> Creatinine	CH000031 SST	<input type="checkbox"/> T3, Total	CH000104 SST	<input type="checkbox"/> HAV Antibodies, Total	CH000042 SST	<input type="checkbox"/> Presurgical SA/MRSA Screen (RT-PCR)	MIP0003
<input type="checkbox"/> CRP	CH000014 SST	<input type="checkbox"/> T3, Uptake	CH000063 SST	<input type="checkbox"/> HAV Antibody, IgM	CH000043 SST	<input type="checkbox"/> Presurgical SA/MRSA Culture	MI000169
<input type="checkbox"/> CRP, High Sensitivity	CH000015 SST	<input type="checkbox"/> T4, Free	CH000069 SST	<input type="checkbox"/> Hepatitis B Core Antibody, IgM	CH000044 SST	<b>URINE TESTING</b>	
<input type="checkbox"/> Ferritin	CH000037 SST	<input type="checkbox"/> T4, Total	CH000117 SST	<input type="checkbox"/> Hepatitis B Core Antibody, Total	CH000119 SST	<input type="checkbox"/> UA, Chemistry Only (Dipstick)	UA003 U
<input type="checkbox"/> Glucose, Random	CH000040 SST	<input type="checkbox"/> TSH	CH000101 SST	<input type="checkbox"/> Hepatitis B Surface Antibody	CH000045 SST	<input type="checkbox"/> UA, Complete (Dip + Microscope)	UA001 U
<input type="checkbox"/> Hemoglobin A1C	SC000100 SST	<input type="checkbox"/> TSH w/ Reflex to FT4	CHP0014 SST	<input type="checkbox"/> Hepatitis B Surface Ag, Rflx to Confirm.	CH000106 SST	<input type="checkbox"/> UA, Complete w/ Reflex to Culture	UA002 U
<input type="checkbox"/> HCG, Beta Quantitation	CH000068 SST	<b>HORMONE &amp; ENDOCRINOLOGY TESTING</b>		<input type="checkbox"/> HCV Antibody w/ Rflx to Confirmation	CH000046 S	<input type="checkbox"/> Urine, Culture Only	M_URINE V
<input type="checkbox"/> Homocysteine	CH000098 SST	<input type="checkbox"/> Estradiol	CH000035 SST	<input type="checkbox"/> HIV Ag/Ab (4th Gen) w/ Rflx to Confirm.	CH000066 S	<b>NOTES &amp; ADDITIONAL TESTING</b>	
<input type="checkbox"/> Insulin, Random	CH000107 SST	<input type="checkbox"/> FSH	CH000039 SST	<input type="checkbox"/> HSV-1, IgG	CH000113 SST	*Panel descriptions can be found on our website at averodx.com/clinical	
<input type="checkbox"/> Iron	CH000090 SST	<input type="checkbox"/> LH	CH000116 SST	<input type="checkbox"/> HSV-2, IgG	CH000114 SST		
<input type="checkbox"/> LDH	CH000077 SST	<input type="checkbox"/> Progesterone	CH000105 SST	<input type="checkbox"/> Measles (Rubeola) Antibodies, IgG	096560 SST		
<input type="checkbox"/> Lipase	CH000096 SST	<input type="checkbox"/> Prolactin	CH000115 SST	<input type="checkbox"/> Quantiferon Gold, TB	CHP0055 G		
<input type="checkbox"/> Magnesium	CH000093 SST	<input type="checkbox"/> Sex Hormone Binding Complex (SHBG)	CH000108 SST	<input type="checkbox"/> Rubella Antibodies (IgG)	CH000103 SST		
<input type="checkbox"/> Phosphorus	CH000092 SST	<input type="checkbox"/> Testosterone, Total	CH000102 SST	<input type="checkbox"/> SARS-Cov-2 Anti-Nucleocapsid, Total IgG/IgM	CH000140 SST		
<input type="checkbox"/> Prealbumin	CH000095 SST	<input type="checkbox"/> Testosterone Profile, Adult Male	CHP0024 SST	<input type="checkbox"/> SARS-Cov-2, Anti-Spike Protein IgG	CH000147 SST		
<input type="checkbox"/> Protein/Creatinine Ratio, Urine	UNP0002 SST	<input type="checkbox"/> Testosterone, Free, Direct	LC-144980 SST	<input type="checkbox"/> T. pallidum Ab (Syphilis) Rflx to Confirm.	CH000120 SST		
<input type="checkbox"/> PSA, Total	CH000053 SST	<input type="checkbox"/> Testosterone, Total/Free Direct	CHP0048 SST	<input type="checkbox"/> Varicella Zoster V Ab, IgG	LC-096206 SST		
<input type="checkbox"/> Vitamin B12	CH000111 SST	<input type="checkbox"/> >= 18 yoa					
<input type="checkbox"/> Vitamin D, 25 Hydroxy	CH000118 SST						



**A. Notifier:** \_\_\_\_\_

**B. Patient Name:** \_\_\_\_\_ **C. Identification Number:** \_\_\_\_\_

### ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for **D.** \_\_\_\_\_ 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 **D.** \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay	F. 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 **D.** \_\_\_\_\_ 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.

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

- ☐ **OPTION 1.** I want the **D.** \_\_\_\_\_ 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 **D.** \_\_\_\_\_ 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 **D.** \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

#### H. 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.

I. Signature	J. Date

Form CMS-R-131 (Exp. 06/30/2023)

Form Approved OMB No. 0938-0566

#### CMS does not discriminate in its programs and activities.

**To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov)**

*According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.*