CLINICAL REQUISITION

PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY) | PATIENT MRN

TELEPHONE NUMBER

SEX
☐ Female ☐ Male ☐ Other/Unknown

STREET NUMBER | STREET NAME | APT NUMBER

CITY | STATE | ZIP

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.

PATIENT SIGNATURE | DATE (MM/DD/YY)
X

SPECIMEN INFORMATION – REQUIRED

Collected on: | Fasting: HRS

Time: : ☐ AM ☐ PM | Urine hrs/vol: HRS VOL

CLINICIAN INFORMATION

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 tests(s) requested herein.

REQUIRED | ORDERING CLINICIAN SIGNATURE | DATE (MM/DD/YY)
X

BILLING INFO

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

INSURANCE COMPANY

IPA NAME

MEMBER ID

☐ **BILL PATIENT** Patient will be contacted to provide payment method.

☐ **CLIENT BILL**

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	Tube
☐ * Basic Metabolic Panel	CHP0002	SST
☐ * Comprehensive Metabolic Panel	CHP0001	SST
☐ * Electrolyte Panel, Serum	CHP0008	SST
☐ * Hepatic Function Panel	CHP0005	SST
☐ * Iron and Iron Binding Capacity	CHP0013	SST
☐ * Lipid Panel w/ Calculated LDL	CHP0003	SST
☐ * Lipid Panel w/ Rflx to Direct LDL	CHP0016	SST
☐ * Renal Function Panel	CHP0011	SST
☐ Albumin	CH000004	SST
☐ Albumin/Creatinine Ratio, Urine	UNP0001	U
☐ Alk Phos	CH000005	SST
☐ ALT (SGPT)	CH000003	SST
☐ Amylase	CH000007	SST
☐ AST (SGOT)	CH000009	SST
☐ Bilirubin, Direct	CH000011	SST
☐ Bilirubin, Total	CH000012	SST
☐ BNP, NT-pro	CH000065	SST
☐ Calcium	CH000016	SST
☐ Chloride	CH000024	SST
☐ CK	CH000030	SST
☐ Cortisol	CH000028	SST
☐ C-Peptide	CH000013	SST
☐ Creatinine	CH000031	SST
☐ CRP	CH000014	SST
☐ CRP, High Sensitivity	CH000015	SST
☐ Ferritin	CH000037	SST
☐ Glucose, Random	CH000040	SST
☐ Hemoglobin A1C	SC000100	SST
☐ HCG, Beta Quantitation	CH000068	SST
☐ Homocysteine	CH000098	SST
☐ Insulin, Random	CH000107	SST
☐ Iron	CH000090	SST
☐ LDH	CH000077	SST
☐ Lipase	CH000096	SST
☐ Magnesium	CH000093	SST
☐ Phosphorus	CH000092	SST
☐ Prealbumin	CH000095	SST
☐ Protein/Creatinine Ratio, Urine	UNP0002	SST
☐ PSA, Total	CH000053	SST
☐ Vitamin B12	CH000111	SST
☐ Vitamin D, 25 Hydroxy	CH000118	SST

HEMATOLOGY & COAG TESTING	CODE	Tube
☐ * CBC w/ Auto Diff, Rflx to Manual Diff	HMP0001	LAV
☐ * CBC w/ No Diff	HMP0003	LAV
☐ * CBC, Auto Diff w/ Anemia Reflex	HMP0001-A	S/L
☐ * Factor II&V (Leiden) PCR (Qualitative)	MIP0002	LAV
☐ ESR	HM000138	LAV
☐ Hemoglobin & Hematocrit	HMP0006	LAV
☐ Platelet Count	HM000107	LAV
☐ Reticulocyte Count	HMP0010	LAV
☐ aPTT	CO000201	B
☐ Fibrinogen Activity	CO000301	B
☐ PT/INR	CO000101	B

THYROID & AUTOIMMUNE TESTING	CODE	Tube
☐ * ANA Diagnostic Panel	AMP00020	SST
☐ * ANA Screen w/ Reflex	AMP0002	SST
☐ * ANCA Profile	AMP0001	SST
☐ * Celiac Disease Panel	AMP0006	SST
☐ * Thyroid Antibodies Panel	AMP0005	SST
☐ * Thyroid Function Panel w/ TSH	CHP0012	SST
☐ Anti-Thyroglobulin	AM000030	SST
☐ Anti-TPO	AM000031	SST
☐ T3, Free	CH000061	SST
☐ T3, Reverse	LC-070104	SST
☐ T3, Total	CH000104	SST
☐ T3, Uptake	CH000063	SST
☐ T4, Free	CH000069	SST
☐ T4, Total	CH000117	SST
☐ TSH	CH000101	SST
☐ TSH w/ Reflex to FT4	CHP0014	SST

HORMONE & ENDOCRINOLOGY TESTING	CODE	Tube
☐ Estradiol	CH000035	SST
☐ FSH	CH000039	SST
☐ LH	CH000116	SST
☐ Progesterone	CH000105	SST
☐ Prolactin	CH000115	SST
☐ Sex Hormone Binding Complex (SHBG)	CH000108	SST
☐ Testosterone, Total	CH000102	SST
☐ Testosterone Profile, Adult Male	CHP0024	SST
☐ Testosterone, Free, Direct	LC-144981	SST
☐ Testosterone, Total/Free Direct >/= 18 yoa	CHP0048	SST

ALLERGY TESTING	CODE	Tube
☐ Cat Component Panel	ALP0005	SST
☐ Dog Component Panel	ALP0006	SST
☐ E. Cascadia Region Respiratory Allergens	ALP0041	SST
☐ Early Childhood Allergen Profile	ALP0001	SST
☐ Egg Component Panel	ALP00013	SST
☐ Food Allergen Profile, Rflx to Components	ALP0043	SST
☐ Fruit Profile (Allergen)	ALP0032	SST
☐ Gluten Profile (Allergen)	ALP0040	SST
☐ Legume Profile (Allergen)	ALP0034	SST
☐ Meat Profile (a-Gal, Beef, Mutton, Pork, Chicken)	ALP00027	SST
☐ Milk Component Panel	ALP00017	SST
☐ Mold Allergy Panel	ALP00029	SST
☐ Northwest Region Resp. Allergen Prof., Rflx to Components	ALP0042	SST
☐ Shrimp Component Panel	ALP00022	SST
☐ Soy Component Panel	ALP00023	SST
☐ Texas/Oklahoma Allergens	ALP0044	SST
☐ Vegetable-Root/Fruit Profile (Allergen)	ALP0039	SST
☐ Vegetable-Leaf Profile (Allergen)	ALP0038	SST
☐ IgE, Total	AL000536	SST
☐ IgE - Specify Allergen(s): ____________		SST

INFECTIOUS DISEASE TESTING	CODE	Tube
☐ HAV Antibodies, Total	CH000042	SST
☐ HAV Antibody, IgM	CH000043	SST
☐ Hepatitis B Core Antibody, IgM	CH000044	SST
☐ Hepatitis B Core Antibody, Total	CH000119	SST
☐ Hepatitis B Surface Antibody	CH000045	SST
☐ Hepatitis B Surface Ag, Rflx to Confirm.	CH000106	SST
☐ HCV Antibody w/ Rflx to Confirmation	CH000046	S/L
☐ HIV Ag/Ab (4th Gen) w/ Rflx to Confirm.	CH000066	S/L
☐ HSV-1, IgG	CH000113	SST
☐ HSV-2, IgG	CH000114	SST
☐ Measles (Rubeola) Antibodies, IgG	CH00159	SST
☐ Quantiferon Gold, TB	CHP0055	G
☐ Rubella Antibodies (IgG)	CH00161	SST
☐ SARS-Cov-2 Anti-Nucleocapsid, Total IgG/IgM	CH000140	SST
☐ SARS-Cov-2, Anti-Spike Protein IgG	CH000147	SST
☐ T. pallidum Ab (Syphilis) Rflx to Confirm.	CH000120	SST
☐ Varicella Zoster V Ab, IgG	CH00162	SST

MICROBIOLOGY

Wound Culture & Sensitivity, w/ Gram Stain	
☐ Aerobic Culture	M_WOUND
☐ Aerobic & Anaerobic Culture	M_AER_ANER

Site: ____________

Source: ____________

Fungal/Yeast Testing	Code
☐ Fungal Culture & CFW Stain	M_FUNGAL
☐ Yeast Culture Only	M_YEAST

Enteric Testing	Code
☐ Calprotectin, Fecal	LC-123255
☐ C. Difficile, Stool	MI000100
☐ GI Pathogen Panel, Stool	MIP0004
☐ H. Pylori Antigen, Stool	LC-180764
☐ Ova & Parasites Exam, Stool	08623
☐ Stool Culture	M_STOOL
☐ Giardia lamblia Ag, EIA	LC-182204

Respiratory Testing	Code
☐ Respiratory Panel w/Sars (PCR)	MIP0010
☐ Sputum, C&S w/ Gram Stain	M_SPUTUM
☐ Strep A w/ reflex to Culture (RT-PCR)	MI000101
☐ Throat Culture	M_THROAT

Other Micro Testing	Code
☐ Presurgical SA/MRSA Screen (RT-PCR)	MIP0003
☐ Presurgical SA/MRSA Culture	M_STAPHSCREEN

URINE TESTING	CODE	Tube
☐ UA, Chemistry Only (Dipstick)	UA003	U
☐ UA, Complete (Dip + Microscope)	UA001	U
☐ UA, Complete w/ Reflex to Culture	UA002	U/V
☐ Urine, Culture Only	M_URINE	V

NOTES & ADDITIONAL TESTING

*Panel descriptions can be found on our website at *averodx.com/clinical*

TUBE LEGEND: SST Serum Separator Tube (SST) · S/L Serum Separator Tube (SST) **AND** K2EDTA Lavender Tube · LAV K2EDTA Lavender Tube · B Sodium Citrate Blue Tube · G Lithium Heparin Green Tube · U Sterile Urine Cup **OR** Urine Vacutainer Tube · U/V Sterile Urine Cup **AND** C&S Grey Urine Vacutainer Tube · V C&S Grey Urine Vacutainer Tube

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AVERO® DIAGNOSTICS

Bellingham Laboratory
3548 Meridian Street, Suite 100
Bellingham, WA 98225
360.527.4580

Dallas Laboratory
6221 Riverside Drive, Suite 119
Irving, TX 75039
877.232.9924

www.averodx.com

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*

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