AVERO DIAGNOSTICS

CL00001

CLINICAL REQUISITION

For Lab Use Only
DO NOT place anything or write in this space.

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** (Cash pay, no insurance)

☐ **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
☐ * 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 U
☐ PSA, Total	CH000053 SST
☐ Vitamin B12	CH000111 SST
☐ Vitamin D, 25 Hydroxy	CH000118 SST

HEMATOLOGY & COAG TESTING	CODE
☐ * CBC w/ Auto Diff, Rflx to Manual Diff	HMP0001 LAV
☐ * CBC w/ No Diff	HMP0003 LAV
☐ * CBC, Auto Diff w/ Anemia Reflex	HMP0001-A SL
☐ * 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
☐ * 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
☐ 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
☐ 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
☐ 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 SL
☐ HIV Ag/Ab (4th Gen) w/ Rflx to Confirm.	CH000066 SL
☐ 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	MI000178
☐ 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
☐ UA, Chemistry Only (Dipstick)	UA003 U
☐ UA, Complete (Dip + Microscope)	UA001 U
☐ UA, Complete w/ Reflex to Culture	UA002 UV
☐ 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) | SL 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 | UV Sterile Urine Cup **AND** C&S Grey Urine Vacutainer Tube | V C&S Grey Urine Vacutainer Tube

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

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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.