

labcorp

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www.labcorp.com

SPECIMEN COLLECTED DATE:

TIME:

BY:

PHOTO ID CHECKED

(Red Indicates Required)

Last	Last	Last
First	First	First
Last	Last	Last
First	First	First

DIAGNOSIS/SIGNS/SYMPTOMS IN ICD-CM format in effect at Date of Service (Highest Specificity REQUIRED) SEND BILL TO (REQUIRED) (___ CLINIC) (___ PATIENT/INS.) DUPLICATE REPORT TO: (PROVIDER'S FULL NAME & ADDRESS)

1. _____ 2. _____ 3. _____ 4. _____ (___ CLINIC) (___ PATIENT/INS.)

PATIENT'S LEGAL NAME (LAST, FIRST, MI) PREVIOUS NAME

SEX DATE OF BIRTH

MAILING ADDRESS (REQUIRED FOR INSURANCE & PATIENT BILLING) APT #

CITY/STATE ZIP PATIENT PHONE NO. ()

INSURANCE CO. NAME & ADDRESS (QR ATTACH COPY OF CARD) PRE AUTHORIZATION #

INSURANCE ID NO. GROUP NO.

MEDICAID / OMAP I.D. NO. MEDICARE NO. & LETTER REFER TO DETERMINING NECESSITY OF ABN COMPLETION ON REVERSE

OREGON GENETICS PRIVACY ACT: OPT OUT

CHARTABLE COMMENT/CHART#: _____

LAST DOSE: DATE _____ TIME _____ FASTING HRS _____ URINE RANDOM TIMED HRS _____ M _____

STAT (IF STAT, PLACE STICKER ON OUTSIDE OF SPECIMEN BAG)
 PHONE RESULTS ()
 FAX RESULTS (To comply with HIPAA, results will only be faxed to the designated number on file at Labcorp).

GYNECOLOGIC CYTOLOGY
 Thin Prep SurePath Reason: Diagnostic Routine
 Cervical Vaginal Undesignated
LMP or #Yrs PMP: _____
 Hx Abn Pap (date & dx:)
Hx Cancer dx: _____
 Hx Positive HPV test (date & type:)
Hysterectomy (cervix intact) _____
 HRT
 Pregnant ___ wks BCP IUD DES
 Post partum ___ wks Abn bleeding
Other Info: _____

HPV Test Options:
 Cotest
 ASCUS only
 Any Abnormal
 None

SURGICAL PATHOLOGY NON GYN CYTOLOGY FINE NEEDLE ASPIRATE

SPECIMEN SOURCE:
1. _____ 2. _____
3. _____ 4. _____

CLINICAL INFORMATION: _____

ABO RH	2L BB ABORH AUTO	LACTATE DEHYDROGENASE	SS LDH	URINE, ALBUMIN/CREATININE RATIO	U ALB/CR	MICROBIOLOGY	
ANA SCREEN W/RFLX	SS ANA R-IFA	LIPASE	SS LIPASE	URINE, PROTEIN/CREATININE RATIO	U TP/CR		
ANTIBODY SCREEN	2L BB ABS AUTO	LITHIUM	SS LI	URINALYSIS (DIP STICK ONLY)**	U DIPSTICK	(SOURCE):	
B12 FOLATE	SS B12, FOL	MAGNESIUM**	SS MG	URINALYSIS W/MICROSCOPY**	U UAMIC	CULTURE, EXUDATE C EX	
BILIRUBIN, DIRECT	SS BIL D	METHYLMALONIC ACID, QUANT	SS MMA	URINALYSIS W/MICRO, RFLX TO CULT**	U UAMIC R	CULTURE, SKIN SUPERFICIAL C SKIN SUP	
B-TYPE NATRIURETIC PEPTIDE**	L BNP	PARATHYROID HORMONE, INTACT	SS PTH-I	VALPROIC ACID	VALP	CULTURE, URINE** CU	
CANCER ANTIGEN 27.29**	SS CA27	PARTIAL THROMBOPLASTIN TIME**	B PTT	VITAMIN D25 HYDROXY	SS VITD 25	CULTURE: _____	
CBC W/AUTO DIFF**	L CBCA	PHOSPHORUS	SS PHOS	ZINC	RB ZIN	GENITAL CULTURES	
CBC W/NO DIFF**	L CBCN	PREALBUMIN	SS PREALB	TESTOSTERONE		CULTURE, ROUTINE C GEN	
CHOLESTEROL**	SS CHOL	PROGESTERONE	SS PROG	TESTOSTERONE, TOTAL-MALE	SS TST T CIA	CULTURE FOR BETA STREP C BS	
CK, TOTAL	SS CK	PROLACTIN	SS PROL	TESTOSTERONE, FREE-MALE	SS TST F CIA	PENICILLIN ALLERGIC? YES ___ NO ___	
COPPER	RB COP	PROTEIN, TOTAL	SS TP	TESTOSTERONE, F&T W/SHBG-MALE	SS TST TRT CIA	MVP ASSAY XPERT MVP	
CREATININE	SS CR	PROTEIN ELECTROPHORESIS, SERUM	SS PELP S, NO	TESTOSTERONE, TOTAL-FEMALE/CHILD	SS TST T LCMSMS	THROAT TESTS	
CYCLIC CITRULLINATED PEPTIDE	SS CCP	PROTEIN ELECTROPHORESIS W/RFLX	SS PELP S, YES	TESTOSTERONE, FREE-FEMALE/CHILD	SS TST F LCMSMS	CULTURE FOR BETA STREP C BS	
DHEA-SULFATE (LEGACY)	SS DHEA TMS	PROTIME W/INR**	B PT-INR	TESTOSTERONE, F&T W/SHBG-FEMALE/CHILD	SS TST TRT LCMSMS	STOOL TESTS	
ESR (SED RATE)	L ESR	PSA**	SS PSA	PANELS		CULTURE, STOOL C ST	
ESTRADIOL	SS ESTRA	PSA ANNUAL SCN-MEDICARE ONLY	SS PSA ANN	SEE REVERSE SIDE FOR PANEL COMPONENTS		GIARDIA/CRYPTOSPORIDIUM SCN OP SCR	
FERRITIN**	SS FTN	QUANTIFERON-TB GOLD PLUS	QF PLUS TB	BASIC METABOLIC PANEL	SS BASIC	PARASITE EXAM PARA COMP	
FSH LH	SS FSH, LH	RETICULOCYTE COUNT	L RTC AUTO	BASIC METABOLIC W/GFR	SS BASICGFR	CLOSTRIDIUM DIFFICILE CD TOXIN	
GAMMA GT*	SS GGT	RHEUMATOID FACTOR	SS RA FACTOR	COMPREHENSIVE METABOLIC PANEL	SS COMP	FECAL IMMUNOASSAY** FE IOB	
HCG, QUANTITATIVE**	SS HCGT	SYPHILIS AB SCN W/RFLX	SS SYPH AB RFLX	COMPREHENSIVE METAB W/GFR	SS COMPGFR	AFB/FUNGUS CULTURES	
HEMOGLOBIN A1C**	L HGBA1C	TACROLIMUS, BLOOD	L FK506	EPSTEIN-BARR VIRUS AB PAN	SS EBV AB PAN	CULTURE, AFB C AFB	
HEMOGLOBIN & HEMATOCRIT**	L HH	THYROID PEROXIDASE AB	SS TPO	HEPATIC FUNCTION PAN	SS HEPFUNC	CULTURE, FUNGUS C F	
HEP B CORE AB, TOTAL	SS HEP B CORE	THYROGLOBULIN AB	SS ATGQ	IMMUNOGLOBULINS	SS IG GAM	MOLECULAR	
HEP B SURFACE AB	SS HEP B SAB	TISSUE TRANSGLUTAMINASE AB	SS TTG IGA	IRON DEFICIENCY**	SS IRON DEF	CHLAMYDIA/GONORRHEA BY PCR CTNG PCR	
HEP B SURFACE AG W/RFLX	SS HEP B SAG	TRIODOTHYRONINE, TOTAL	SS T3T	LIPID PROFILE*	SS LIPR	HERPES SIMPLEX DNA HSV DNA PCR	
HEP C AB SCREEN	SS HEP C AB	TRIODOTHYRONINE, FREE	SS T3F	LIPID PROFILE W/RFLX**	SS LIPRFLX	PERTUSSIS PCR PERTUS PCR	
HIV 1/2 & P24 AG SCN W/RFLX**	SS HIV SCN DIFF	TRIGLYCERIDES**	SS TRIG	RENAL FUNCTION PANEL	SS RENAL	*PROPER LABELING INCLUDES FULL NAME, SSN, DOB, DATE/TIME, & PHLEBOTOMIST INITIALS.	
HOMOCYSTEINE	L HOMO CY QNT	THYROXINE, FREE**	SS T4F	RENAL FUNCTION W/GFR	SS RENALGFR	**INDICATES ABN FORM REQUIRED WHEN DIAGNOSIS CODE PROVIDED DOES NOT MEET MEDICARE MEDICAL NECESSITY.	
IRON**	SS IRON	TSH**	SS TSH				
IRON BINDING CAPACITY**	SS IRON IBC	TSH W/REFLEX**	SS TSHR				
KAPPA/LAMBDA QUANT	SS KAP/LAMB	URIC ACID	SS URIC				

LABCORP USE ONLY	SS	L	U	B	R	GY	GN	S	P	C	Y	F	MISC	REC'D BY	ROE	AUDIT	EDIT
	SST TUBE	LAVENDER	URINE	BLUE	RED	GRAY	GREEN	SERUM	PLASMA	ROYAL BLUE	CULTURE	YELLOW	FROZEN	LCX			

ADDITIONAL TESTING:

NOTE: When ordering tests for which Medicare or Medicaid reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.

LABORATORY/BILLING COPY

NPI
Signature of Physician Authorizing Testing

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

Determining Necessity of Advance Beneficiary Notice of Non-coverage (ABN) Completion*

- Diagnose.** Determine your patient's diagnosis.
- Document.** Write the diagnosis code(s) on the front of the requisition.
- Verify.** Determine if the laboratory test(s) ordered for the patient is subject to Local Coverage Determination or National Coverage Determination. This information can be located in the policies published by your Medicare Administrative Contractor (MAC), CMS, or www.Labcorp.com/MedicareMedicalNecessity. For your convenience, the National Coverage Determinations are listed below.

National Coverage Determinations as of 10/01/2023

Alpha-Fetoprotein: 82105
 Blood Counts: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049
 Carcinoembryonic Antigen (CEA): 82378
 Cardiovascular Disease Screening: 80061, 82465, 83718, 84478
 Collagen Cross Links, Any Method: 82523
 Colorectal Cancer Screening: 81528, 82270, G0328
 Cytogenetic Studies: 86230-88299
 Diabetes Screening Tests: 82947, 82950, 82951
 Digoxin Therapeutic Assay: 80162
 Fecal Occult Blood: 82272
 Gamma Glutamyl transferase (GGT): 82977
 Glycated Hemoglobin: 83036
 Glycated Protein: 82985
 Hepatitis Panel / Acute Hepatitis Panel: 80074
 Histocompatibility Studies: 86812, 86813, 86816, 86817, 86821, 86825, 86826
 Human Chorionic Gonadotropin (hCG): 84702
 Human Immunodeficiency Virus (HIV) Infection Screening: G0432, G0433, G0435, G0475

Human Immunodeficiency Virus (HIV) Testing (Diagnosis): 86689, 86701, 86702, 86703, 87390, 87391, 87534, 87535, 87637, 87538
 Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring): 87538, 87539
 Lipids: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478
 Lymphocyte Mitogen Response Assays: 86353
 Pap Smears, Diagnostic: 88141-88175
 Pap Smears, Screening: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
 Partial Thromboplastin Time (PTT): 85730
 Prostate Cancer Screening Test: G0103
 Prostate Specific Antigen: 84153
 Prothrombin Time: 85610
 Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing: G0476
 Screening for Hepatitis B Virus (HBV) Infection: G0499, 86704, 86706, 87340, 87341
 Screening for Hepatitis C Virus (HCV) in Adults: G0472
 Screening for Sexually Transmitted Infections (STIs): 86592, 86593, 86631, 86632, 86780, 87110, 87270, 87320, 87340, 87341, 87490, 87491, 87590, 87591, 87800, 87810, 87850
 Serum Iron Studies: 82728, 83540, 83550, 84466
 Sweat Test: 82438, 89230
 Thyroid Testing: 84436, 84439, 84443, 84479
 Tumor Antigen by Immunoassay CA 15-3 & CA 27.29: 86300
 Tumor Antigen by Immunoassay CA 19-9: 86301
 Tumor Antigen by Immunoassay CA 125: 86304
 Urine Bacterial Culture: 87086, 87088

- Review.** If the diagnosis code for your patient **does not** meet the medical necessity requirements set forth by Medicare or the test(s) is being performed more frequently than Medicare allows, an ABN should be completed.

*An ABN should be completed for all tests that are considered investigational (experimental or for research use) by Medicare.

How to Complete an Advance Beneficiary Notice of Non-coverage (ABN)

Medicare is very specific in requiring that all of the information included on the ABN be completed. Additionally, Labcorp requests that the specimen number or bar code label be included on the form. To be valid an ABN must:

- Be executed on the CMS approved ABN form (CMS-R-131)
- Identify the Medicare Part B Beneficiary, using the name as it appears on the patient's red, white and blue Medicare card
- Indicate the test(s)/procedure(s) which may be denied within the relevant reason column
- Include an estimated cost for the test(s)/procedure(s) subject to the ABN
- Have "Option 1", "Option 2", or "Option 3" designated by the beneficiary

The following reflex tests will be performed at an additional charge.

- ANA Screen w/titer
 - *If positive, a titer will be performed.
- CBC with Auto Differential
 - *Automated differential included. Manual differential performed when indicated at no additional charge.
- Hepatitis ABC Acute Panel w/reflex
 - *Reactive Hepatitis B Surface Antigen will reflex to the Hepatitis B Surface Antigen Confirmatory neutralization test for an additional charge.
- Hepatitis Chronic Panel
 - *Reactive Hepatitis B Surface Antigen will reflex to the Hepatitis B Surface Antigen Confirmatory neutralization test for an additional charge. Reactive Hepatitis B Core Antibody will reflex to the Hepatitis B Core IgM antibody for an additional charge.
- Hepatitis B Surface Antigen w/reflex
 - *If positive, a confirmatory neutralization test will be performed.

Prenatal Panels w/reflex

- *Prenatal panels containing one or more of the following components, Syphilis Antibody Scn w/Reflex, Urinalysis with Microscopy w/Cult reflex or CBC with Auto Differential, will have additional tests performed as described.
- Protein Electrophoresis w/Reflex
 - *If indicated, immunofixation and quantitative immunoglobulins will be performed
- Syphilis Antibody Scn w/Reflex
 - *If reactive or equivocal, confirmatory tests (RPR and TPPA) will be performed.
- Urinalysis with Microscopy w/Cult reflex
 - *If indicated, a urine culture will be performed
- TSH w/reflex
 - *Any low or high TSH result will automatically reflex to a Free T4.

A.M.A. Organ / Disease Panels

Basic Metabolic	Na, K, Cl, CO2, Glucose, BUN, Creatinine, Calcium
Comprehensive Metabolic	Na, K, Cl, CO2, Glucose, BUN, Creatinine, Calcium, Protein Total, Albumin, ALT, AST, Alk Phos, Bilirubin Total
Electrolytes	Na, K, Cl, CO2
Hepatic Function	Albumin, AST, ALT, Alk Phos, Bilirubin Total & Direct, Protein Total
Hepatitis ABC Acute	Hep A IgM, Hep B Surface Ag, Hep B Core IgM, Hep C Ab
Lipid Profile	Cholesterol, Triglycerides, HDL, LDL Calculated, Chol/HDL ratio
Renal Function	Albumin, Calcium, CO2, Cl, Creatinine, Glucose, K, Phosphorus, Na, BUN

Prenatal Panels	1	2	4	5	Update
ABO/Rh	X	X	X	X	
Antibody Screen	X	X	X	X	X
Syphilis Antibody SCN w/Reflex	X	X	X	X	
Rubella IgG	X	X	X	X	
HBsAg w/reflex	X	X	X	X	
Urinalysis with Microscopy w/Cult reflex	X				
CBC with Auto Differential	X	X	X	X	
Random Glucose			X		
Glucose OB Screen					X
Toxoplasma IgG				X	

Hepatitis Panels	Acute A,B,C	Chronic
HAVAb IgM	X	
HBsAg w/reflex	X	X
HBsAb		X
HBCAb IgM	X	
HBCAb Total		X
HCvAb	X	X

Misc. Panels

Arthritis Screen	ANA, Rheumatoid Factor Quant, HS C-Reactive Protein
Celiac Disease Panel	Endomysial Ab IgA, Gliadin Ab IgG & IgA, Reticulin Ab IgA, Tissue Transglutaminase Ab IgA
ENA Screen	RNP Ab, Smith Ab, SSA (Ro), SSB (La), Scleroderma Ab
Iron Deficiency Panel	Iron, Iron Binding Capacity, % Iron Sat, Ferritin
Lupus Anticoagulant Panel w/Serology	PT/PTT, LA Test (Dilute Russell's Viper Venom Test or dRVVT), Cardiolipin Antibody (IgG, IgM, IgA), Beta2 Glycoprotein-1 Antibody (IgG, IgM, IgA)
Lupus Anticoagulant Panel without Serology	PT/PTT, LA Test (Dilute Russell's Viper Venom Test or dRVVT)
PIH Panel	Creatinine, BUN, SGOT, Uric Acid
Testosterone Panel	Testosterone, Total and Free, Sex Hormone Binding Globulin

Profile Policy

Labcorp's policy is to provide physicians, in each instance, with the flexibility to choose appropriate tests for the individual patient, including the convenience of ordering test combinations/profiles. This flexibility does not distance physicians from making deliberate decisions regarding which tests are medically necessary. In addition, the physician should only order those tests that he or she believes are medically necessary for each patient, and a lesser inclusive profile or individual tests should be ordered if not all tests in the test combination/profile are medically necessary. All tests offered in test combinations/profiles may be ordered separately.