Manual request completion instructions

Billing indications and requirements

Allina Health LABORATORY

If you wish us to ***bill your clinic or facility***, complete the following sections of the request form:

1. Mark "CLIENT"
2. Date & time of sample collection
3. Patient's name (Last, First MI)
4. Gender
5. Birth date
6. Patient's address - Street & city
7. Patient's address - State & Zip
8. Patient's telephone number
9. Ordering provider

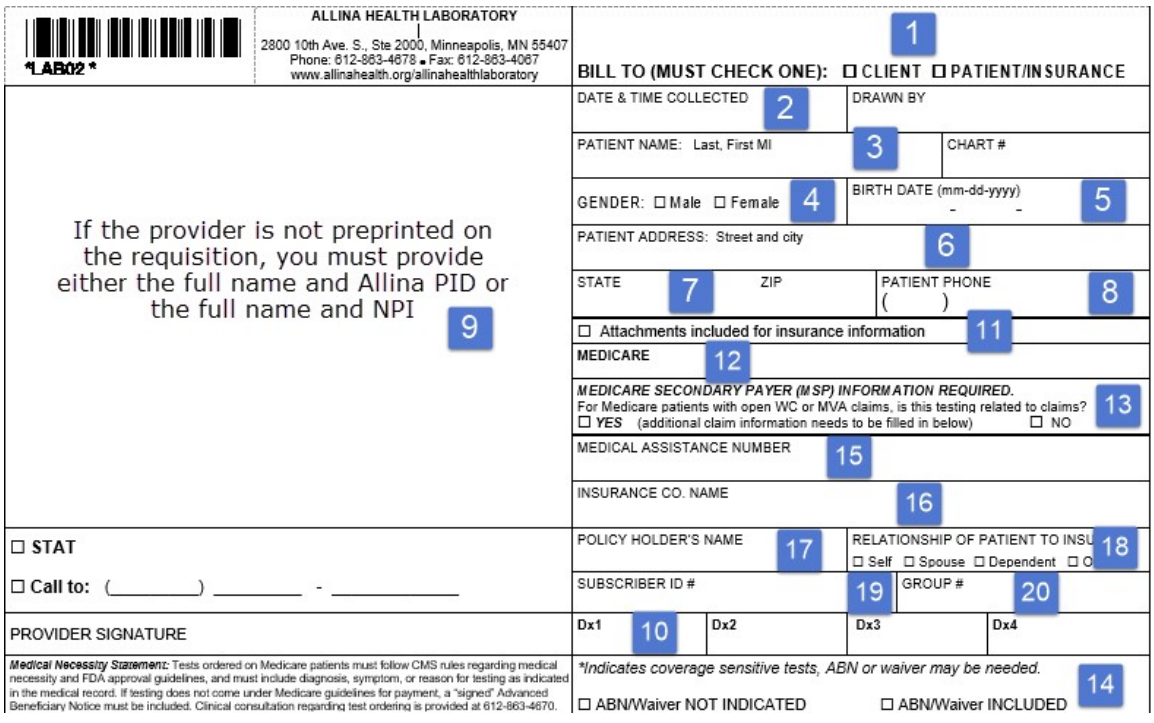
If you wish us to ***bill the patient directly***, complete the following sections of the request form:

1. Mark "PATIENT/INSURANCE"
2. Date & time collected
3. Patient's name (Last, First MI)
4. Gender
5. Birth date
6. Patient's address - Street & city
7. Patient's address - State & Zip
8. Patient's telephone number
9. Ordering provider
10. Diagnosis*
17. Policy Holder (If not patient); also used for Guarantor if patient is under 18 years of age. If different, please list.

If you wish us to **bill Medicare, Medicaid or other third-party payers**, we must have the following sections of the request form completed:

1. Mark "PATIENT/INSURANCE"
2. Date & time of sample collection
3. Patient's name (Last, First MI)
4. Gender
5. Birth date
6. Patient's address - Street & city
7. Patient's address - State & Zip
8. Patient's telephone number
9. Ordering Provider
10. Diagnosis*
13. If Medicare is to be billed, indicate if the work is related to an open WC or MVA claim
14. Indicate whether an ABN/waiver is *not indicated* or *included*
11. Mark *Attachments included for insurance information* ***or complete the following additional insurance information:***
12. Medicare #
15. Medical Assistance # and state in which it was issued
16. Insurance company name
17. Policy Holder (If not patient); also used for Guarantor if patient is under 18 years of age. If different, please list
18. Relationship of patient to insured
19. Subscriber ID#
20. Group #

*ICD codes or clear diagnostic symptom descriptions are required to the highest specificity



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Additional information:

Item #	*Notes*
1	If the request comes in with a sample to Allina Health Laboratory with no bill type marked, the default is to bill the clinic. If the patient presents at one of our draw sites and no bill type is marked, the default is to bill patient/insurance.
3	Enter the full legal name of the patient, no nicknames, etc. This must match what insurance has on file for the patient, or they will reject the claim.
6 - 8	Patients' current and complete mailing address and phone number.
9	The ordering provider must be indicated; 1. If preprinted, circle the name and Allina Health Provider ID number on the request form 2. If the provider is not preprinted on the request form: a. If you know the ordering providers Allina Health Provider ID number, write the number and full name. b. If you do not know the providers Allina Health Provider ID number, write the providers full name, credentials and National Provider Identifier (NPI) number.
10	A complete, valid ICD code is required in order for Allina Health to bill insurance*. ***This cannot be a "rule out" or the word "screen".*** We need the specific information as to why the tests were ordered. Often the codes must have a 4th and even 5th digit in order to bill out for the laboratory services.
12	Medicare number and the suffix is required if Allina Health Laboratory is to bill Medicare. Simply using the patient's SSN is not accurate or complete.
16	Enter the full name of the insurance company (no abbreviations). If we cannot determine what this is, we will send a communication requesting additional information.
17-18	This should be the person who holds the insurance policy. For minors this is also the Guarantor, so Allina Health Laboratory can bill out the claim if needed. Check the relationship between the patient and the policyholder.
19-20	Enter the full complete insurance company identification number. Often the group number is listed separately so that must be included.