Manual request completion instructions

Billing indications and requirements

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

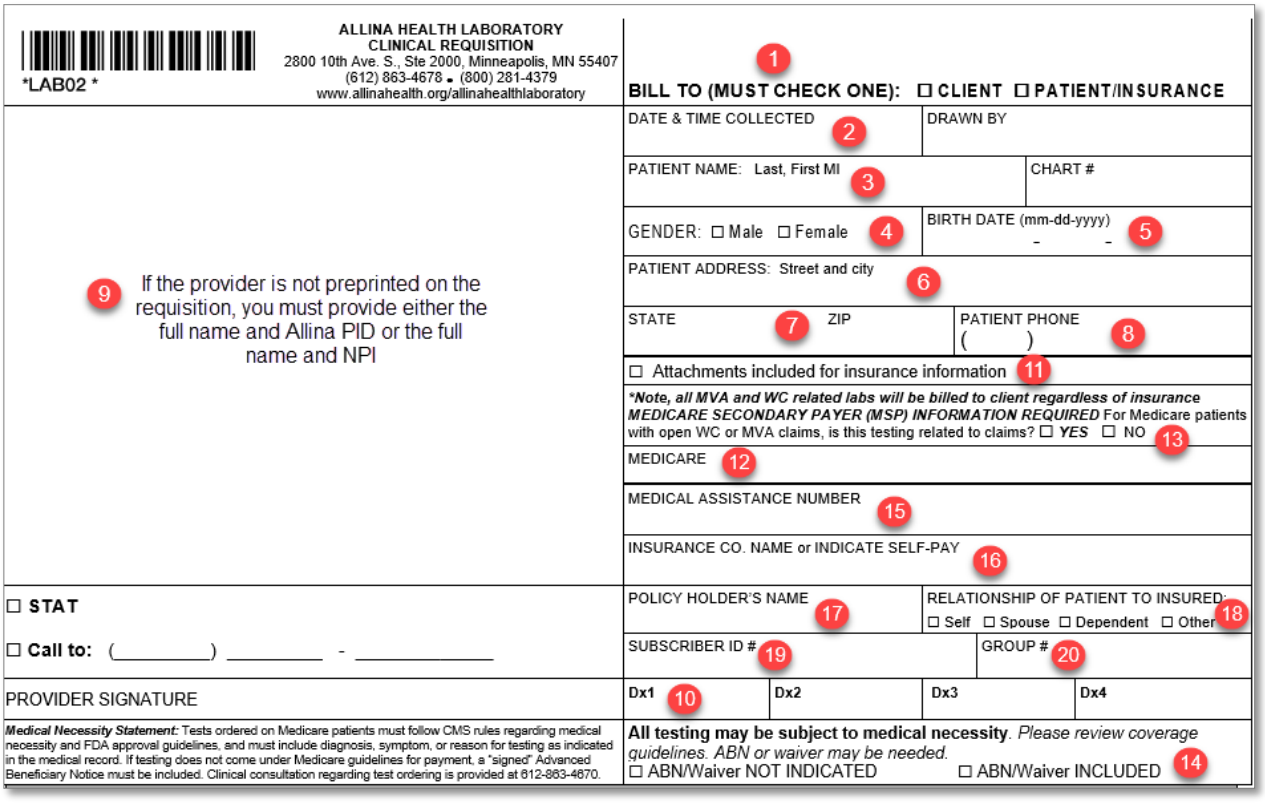
If you wish us to ***bill the patient directly***, complete the following sections of the request form:

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
16. Indicate Self-Pay
17. Guarantor's name if patient is under 18 years of age.

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

**Please refer to Lab billing page, "Billing options & remittance of payment" tab for billing exceptions*

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, charges will be billed to client/facility
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. Name of Policy Holder
18. Relationship of patient to Policy Holder (insured)
19. Subscriber ID#
20. Group #



*LAB02 *

ALLINA HEALTH LABORATORY
CLINICAL REQUISITION
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
(612) 863-4678 • (800) 281-4379
www.allinahealth.org/allinahealthlaboratory

1 **BILL TO (MUST CHECK ONE):** ☐ CLIENT ☐ PATIENT/INSURANCE

DATE & TIME COLLECTED 2 | DRAWN BY

PATIENT NAME: Last, First MI 3 | CHART #

GENDER: ☐ Male ☐ Female 4 | BIRTH DATE (mm-dd-yyyy) - - 5

PATIENT ADDRESS: Street and city 6

STATE 7 ZIP | PATIENT PHONE ( ) 8

9 If the provider is not preprinted on the requisition, you must provide either the full name and Allina PID or the full name and NPI

☐ Attachments included for insurance information 11

Note, all MVA and WC related labs will be billed to client regardless of insurance
MEDICARE SECONDARY PAYER (MSP) INFORMATION REQUIRED For Medicare patients with open WC or MVA claims, is this testing related to claims? ☐ ***YES*** ☐ NO 13

MEDICARE 12

MEDICAL ASSISTANCE NUMBER 15

INSURANCE CO. NAME or INDICATE SELF-PAY 16

☐ **STAT**

☐ **Call to:** (_____) _____ - _____

POLICY HOLDER'S NAME 17 | RELATIONSHIP OF PATIENT TO INSURED: ☐ Self ☐ Spouse ☐ Dependent ☐ Other 18

SUBSCRIBER ID # 19 | GROUP # 20

PROVIDER SIGNATURE

Dx1 10 | Dx2 | Dx3 | Dx4

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines, and must include diagnosis, symptom, or reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment, a "signed" Advanced Beneficiary Notice must be included. Clinical consultation regarding test ordering is provided at 612-863-4670.

All testing may be subject to medical necessity. *Please review coverage guidelines. ABN or waiver may be needed.*
☐ ABN/Waiver NOT INDICATED ☐ ABN/Waiver INCLUDED 14

Manual request completion instructions

Billing indications and requirements

Additional information:

Item #	*Notes*
1	If the request comes in with a sample to Allina Health Laboratory with no bill type marked, charges will be billed to your facility. If the patient presents at one of our draw sites and no bill type is marked, charges will be billed to the patient's insurance or the patient (self-pay) if there is no 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 to the highest specificity is required for Allina Health to bill insurance and must meet medical necessity when indicated.
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.
14	The client is responsible for reviewing medical necessity guidelines. Failure to provide coverable diagnosis codes or a signed ABN/waiver will result in charges being billed to the client/facility.
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.