*LAB06 *

ALLINA HEALTH LABORATORY
FINE NEEDLE ASPIRATE

2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
Phone: 612-863-4678 • Fax: 612-863-4067
www.allinahealth.org/laboratory

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

☐ MEDICARE SECONDARY PAYER (MSP) INFORMATION REQUIRED. (INTERNAL USE ONLY) MSP status has been verified with beneficiary or representative within 90 days of service and documentation is on file. ☐ **MSP Collected**

Submitter: XADO (Opt OUT/Non-Participating Patient)

Facility Name:____________________________________

Address: ____________________________________

____

Phone:____________________________________

Complete Provider Name:________________________

-AND-

Provider Allina Health ID Number:__________________

-OR-

Provider NPI Number:__________________________

☒**Fax report to** (______) ________- ____________

INSURANCE

DATE & TIME COLLECTED		DRAWN BY
GENDER: ☐ MALE ☐ FEMALE		BIRTH DATE (MM-DD-YYYY) - -
PATIENT NAME: LAST, FIRST M.I.		CHART #
PATIENT ADDRESS: STREET and CITY		
STATE	ZIP	PATIENT PHONE ( )
☐ **MEDICARE PRIMARY** ☐ **MEDICARE SECONDARY**		
MEDICARE		
MEDICAL ASSISTANCE NUMBER		STATE
INSURANCE CO. NAME		RELATIONSHIP OF PATIENT TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPEND. ☐ OTHER
POLICY HOLDER'S NAME		POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) - -
SUBSCRIBER ID #		GROUP #

FNA Cytology Aspirate (6301C and 12482)

FNA done by Dr: ____________________________________

☐ Clinician ☐ Radiologist ☐ Pathologist ☐ Surgeon

Source/Site A: ____________________________ ☐ FNA ☐ Core bx

Source/Site B: ____________________________ ☐ FNA ☐ Core bx

Source/Site C: ____________________________ ☐ FNA ☐ Core bx

Dx1	**Dx3**
Dx2	**Dx4**

PROVIDER SIGNATURE

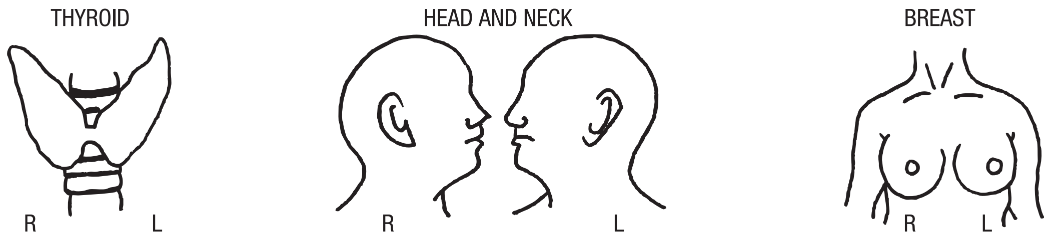
REFERRING PROVIDER

☐ ABN NOT INDICATED
☐ ABN INCLUDED
**Indicates coverage sensitive tests, ABN may be needed.*

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.

CLINICAL INFORMATION ***(Clinical Findings, Pertinent History, Clinical Impression, Comments, etc.)***

As applicable, please indicate the location, size and consistency of the lesion aspirated on the drawing below.



SPECIMENS SUBMITTED:

Slides/Other	***Source A***	***Source B***	***Source C***
# Air dried	____	____	____
# Fixed	____	____	____
Cytolyt	____	____	____
RNA Retain	____	____	____
*ThyGenEx**			
RPMI	____	____	____
Other Misc	____	____	____
Formalin	____	____	____
B+	____	____	____

Time in:	***Source A***	***Source B***	***Source C***
Formalin	____	____	____
B+	____	____	____

:

☐ Verified Patient Name & DOB Tech Initials____________
☐ Verified Site Tech Initials____________

Adequacy assessed by Path? ☐ Yes ☐ No (Initial) ____________________
Prep/Stain Quality Acceptable? ☐ Yes ☐ No (Initial) ____________________
QA Notes:

Preliminary Impression:

Apply

RQ label

here

CYTOL-FNA (04/2017)

☐ Ordered by (A#) ______________________________