LAB12

ALLINA HEALTH LABORATORY
MOLECULAR PATHOLOGY
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
SOCIAL SECURITY # - - ☐ 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 #

Dx1	**Dx3**	PHYSICIAN SIGNATURE
Dx2	**Dx4**	REFERRING PHYSICIAN

☐ 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.

	Test #	Name	Test Questions
☐	5453* 12379	Gene Rearrangements	Source:____________ Path Case #: ____________ ☐ T Cell ☐ B Cell ☐ T&B Cell
☐	12365* 12379	BRAF V600 Mutation Analysis	Path Case #:____________ Indication: ☐ Melanoma ☐ Other
☐	5520*	Cystic Fibrosis Screen	
☐	12366* 12379	EGFR Mutation Analysis	Path Case #:____________ ALK Reflex Testing? ☐ Yes ☐ No
☐	**5635***	Factor V Leiden	
☐	**2260***	Factor II Mutation	
☐	**5638***	Hereditary Hemochromatosis	
☐	6595*	HPV High Risk Types	
☐	7867*	HIV RNA Quant-Taqman	
☐	2242*	HCV RT-PCR Viral Load	
☐	**7781***	JAK2 V617F Mutation Detection	Source:____________ Reflex to Calreticulin Exon 9 Assay? ☐ Yes ☐ No
☐	**12372***	Calreticulin Exon 9 Assay	JAK2 Status:

Any combination of the tests in **BOLD** above can be performed off of one tube.

OTHER REQUESTS OR SPECIAL INSTRUCTIONS:

Affix

RQ Label

Here

REFERENCE LAB USE ONLY

TUBE(S) RECEIVED: SST_____ EDTA (purple)_____ Plain Red_____ NaCitrate (blue)_____ Transfer tube_____ Frozen_____ **SPECIMENS COLLECTED:** Urine_____ Culturette_____ M4_____ Stool_____ DNA Probe_____

 Ordered by (A#) ____________________