Molecular Medicare billing request

Allina Health LABORATORY

FACILITY INFORMATION	
Facility name	
Contact name	
Contact phone number	
SAMPLE/TEST INFORMATION	
Date of collection	
Test name	
PATIENT INFORMATION	
Name (Last, First MI)	
Date of birth	
Address – Street	
Address – City, state & ZIP	
Patient type:	☐ Hospital inpatient ☐ Hospital outpatient ☐ Clinic patient
INSURANCE	
Primary insurance	
Name	
Subscriber ID	
Secondary insurance	
Name	
Policy #	
Group #	
Guarantor if patient is under the age of 18	
Name	
Relationship	
ORDERING PROVIDER	
Name (Last, First MI)	
NPI	
DIAGNOSIS*	
ICD10 code(s) or clinical information for tissue submission:	
**ICD10 codes provided must meet medical necessity per LCD (L35000) or a copy of a signed ABN/Financial waiver must be included for this testing.*	

A detailed face sheet will be accepted, but must include complete subscriber information. In addition, the date of sample collection, ordering provider's name and NPI, as well as all applicable diagnosis codes will need to be indicated on the document.

Fax the completed form to Allina Health Lab Billing at (612) 863-0460

Note: Incomplete forms will not be processed