

Manual Request Billing Instruction Guide

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

1. **YOU MUST MARK** "Clinic/Facility"
3. Date & Time Collected
4. Patient's Social Security Number (optional/not required)
5. Sex
6. Birth Date
7. Patient's Name (Last, First, MI)
9. **Patient's Address - Street & City**
10. **Patient's Address - State & Zip**
11. Patient's Telephone Number
22. Ordering Provider

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

2. **YOU MUST MARK** "Insurance/Patient (Self-Pay)"
3. Date & Time Collected
4. Patient's Social Security Number (optional/not required)
5. Sex
6. Birth Date
7. Patient's Name (Last, First, MI)
9. **Patient's Address - Street & City**
10. **Patient's Address - State & Zip**
11. Patient's Telephone Number
15. Guarantor listed here if patient under 18 years of age
21. Diagnosis*
22. Ordering Provider

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

2. **YOU MUST MARK** "Insurance/Patient (Self-Pay)"
3. Date & Time Collected
4. Patient's Social Security Number (optional/not required)
5. Sex
6. Birth Date
7. Patient's Name (Last, First, MI)
9. **Patient's Address (Street & City)**
10. **State & Zip**
11. Patient's Telephone Number
12. For Medicare patients only, the appropriate box on the requisition should be checked to indicate if Medicare is Primary or Secondary.
13. Medicare #
14. Medical Assistance # and state in which it was issued
15. Policy Holder (If Not Patient)–also used for Guarantor if patient under 18 years of age. If different, please list
16. Policy Holder's Date of Birth
17. Member/Policy #
18. Group #
19. Relationship of Patient to Insured
20. Insurance Company Name
21. Diagnosis*
22. Ordering Provider

 ALLINA HEALTH LABORATORY CLINICAL REQUEST 2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407 Phone: 612-863-4678 • Fax: 612-863-4067 www.allinahealth.org/laboratory *LAB02*	BILL TO: MUST CHECK ONE <input type="checkbox"/> CLINIC/FACILITY <input type="checkbox"/> INSURANCE/PATIENT (SELF-PAY)	
	1	2
<input type="checkbox"/> 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. <input type="checkbox"/> MSP Collected		
22	DATE & TIME COLLECTED 3	DRAWN BY
	SOCIAL SECURITY # 4	<input type="checkbox"/> MALE 5 BIRTH DATE 6 / / <input type="checkbox"/> FEMALE
	PATIENT NAME (LAST) 7 (FIRST) (M.I.)	CHART # 8
	PATIENT ADDRESS (STREET) 9 CITY	
	STATE 10 ZIP	PATIENT PHONE 11 () ()
	<input type="checkbox"/> MEDICARE PRIMARY <input type="checkbox"/> MEDICARE SECONDARY 12	
	MEDICARE 13	
	MEDICAL ASSISTANCE NUMBER 14	STATE
	INSURANCE CO. NAME 20	RELATIONSHIP OF PATIENT TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPEND. <input type="checkbox"/> OTHER 19
	POLICY HOLDER'S NAME 15	POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) / 16
SUBSCRIBER ID # 17	GROUP # 18	
Additional Tests		
Dx1 21	Dx3	PHYSICIAN SIGNATURE
Dx2	Dx4	REFERRING PHYSICIAN
<input type="checkbox"/> ABN NOT INDICATED <input type="checkbox"/> ABN INCLUDED <small>*Indicates coverage sensitive tests. ABN may be needed.</small>		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.

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