LabCorp
INDIANA, INC.
530 North Lafayette Boulevard
South Bend, IN 46601-1098

WOMEN'S HEALTH REQUISITION

J.L. Simpson MD
Medical Director

Client Code: ( ) Name:_____
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

Signature of Ordering Provider _____ **Date**_____
(Signature must be dated, legible, and include first and last name)

PATIENT INFORMATION – Please PRINT
Name _____
Last First MI
SS#_____
DOB _____ SEX_____
MO/DAY/YEAR

SPECIMEN COLLECTION
Date_____
MO/DAY/YEAR
Collector's Initials_____
Time:_____ ☐ AM ☐ PM
Fasting ☐ Yes ☐ No

BILLING (SEE REVERSE)
☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE
IF NO BILLING INFORMATION IS PROVIDED, AND NO BOX IS CHECKED YOUR ACCOUNT WILL BE BILLED.

REMINDER: IF YOU HAVE REQUESTED ANY TEST INDICATED IN **BOLD** OR NOTED WITH AN **ASTERISK (*)**, THE PATIENT MAY NEED TO SIGN THE ADVANCE BENEFICIARY NOTICE (ABN). REFER TO THE SOUTH BEND MEDICAL FOUNDATION WEBSITE, WWW.SBMF.ORG

PRIORITY: ☐ **Routine** ☐ **Phone** ☐ **STAT** ☐ **Fax #** _____
SEE REVERSE SIDE FOR ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Copy to Physician(s): Use complete name(s)

TEST PANELS	ICD-10 DX CODE	TEST PANELS	ICD-10 DX CODE
☐ **28192 Acute Hepatitis Panel***		☐ 29527 Metabolic Panel, Comprehensive	
☐ 35205 General Health Panel		☐ 35851 Obstetric Panel w/Reflex	
☐ **29525 Hepatic Function Panel***			
☐ **29048 Lipid Panel***		☐ 29528 Renal Function Panel	
☐ 29526 Metabolic Panel, Basic			

TESTS	ICD-10 DX CODE	TESTS	ICD-10 DX CODE
☐ 22014 ABO Blood Group and RH Type, Neonatal		☐ **28272 HIV Ag-Ab w/HIV-1/2 (if nd)***	
☐ 22000 ABO+RH Type		☐ **30144 Homocysteine-Serum/Plasma***	
☐ **25039 Activated Partial Thromboplastin (APTT)***		☐ 28074 HSV1+HSV2 ABS, IGG/M	
☐ **30098 AFP, Maternal NTD*** ***Info below required for testing.** **EDD_____ WT_____ #Fetus_____** **Race_____ Insulin?** ☐ Yes ☐No **Repeat Spec?** ☐ Yes ☐No		☐ **29100 Iron (include IBC)***	
		☐ 30096 LH-Serum/Plasma	
		☐ **25243 Lupus Anticoagulant Detection***	
		☐ **23084 Magnesium***	
		☐ **36130 MTHFR C677T+A1298C Mutations***	
☐ 28312 ANA MFI Screen, IGG		☐ **30080 Prenatal Risk3*** ☐ **30180 Prenatal Risk4*** ***Info below required for testing.** **EDD_____ WT_____#Fetus_____ Race_____** **Insulin?** ☐Yes ☐No **Repeat Spec?** ☐ Yes ☐No	
☐ 44462 Bile Acids Total			
☐ 23203 Bilirubin, Direct		☐ 30200 Progesterone	
☐ 23204 Bilirubin, Total		☐ 30097 Prolactin	
☐ **30225 CA125***		☐ 29037 Protein, Total w/ Creatinine Ratio, Urine, Random	
☐ 35187 Cardiolipin ABS, IGG/M		☐ **25045 Prothrombin Time***	
☐ **25517 CBC w/Differential***		☐ 28089 RH Immunization Prevention Panel (RH type, Antibody Screen)	
☐ **25014 CBC w/o Differential***			
☐ **36360 Chlamydia Trachomatis and Neisseria Gonorrhoeae by NAA, Urine***		☐ 28036 Rubella AB, IGG	
☐ 29131 Creatinine		☐ 25067 Semen Analysis, Routine	
☐ 30123 DHEA-S		☐ 29255 SGOT (AST)	
☐ **29072 Drug Screen 8, Urine***		☐ 25169 Sickle Cell Screen	
☐ 30085 Estradiol, IA		☐ 36042 Streptococcus Group B by Culture-Enhanced NAA	
☐ **36001 Factor V Leiden Mutation, PCR***		☐ **30016 T3, Free***	
☐ **30055 Ferritin***		☐ **30113 T4, Free***	
☐ 28095 Fetal Fibronectin		☐ 30033 Testosterone, Bioavailable	
☐ 30093 FSH-Serum/Plasma		☐ 30101 Testosterone, Total IA	
☐ 29004 Glucose Challenge-50G Gest		☐ 30019 Thyroid Peroxidase AB	
☐ **29056 Glucose Tolerance, 2 HR Non-Gest***		☐ **28439 Syphilis Total Antibody w/Reflex to RPR and TP-PA, Serum***	
☐ 29057 Glucose Tolerance, 3 HR Gest		☐ **30017 TSH***	
☐ **28183 HBSAG***		☐ 25075 Urinalysis w/Microscopic	
☐ 30089 HCG, Qualitative		☐ 25076 Urinalysis, Macroscopic	
☐ 30088 HCG, Quantitative, serum		☐ 29169 Uric Acid, Serum or Plasma	
☐ 28031 HDN AB		☐ 28175 Varicella Antibody, IgG	
☐ **23409 Hemoglobin A1c***		☐ **30054 Vitamin D, 25-Hydroxy**	
☐ **28194 Hepatitis C Antibody***		☐ **Other:**	
☐ **25316 Hgb & Hct***			

PLEASE FAX ORDERS TO LABCORP AT 574.807.3010

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For our locations and hours
Please visit our website @
www.sbmf.org or call us at
574-234-4176 and press 5
800-544-0925 and press 5

INSURANCE INFORMATION

Responsible Party Name (Required if patient is a minor):

Responsible Party Address:

City | State | Zip

Responsible Party Phone

( ) _____ - _____

☐ Medicare # _____

☐ Medicaid # _____ EDD _____ MM/DD/YY

☐ Primary Insurance (Complete or attach copy of insurance card.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

☐ Secondary Insurance (Complete or attach copy of insurance card front & back.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

IMPORTANT
A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, ONLY TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED.

MICROBIOLOGY PROTOCOL
MICROBIOLOGY CULTURES MAY INCLUDE CHARGES FOR ONE PRIMARY SOURCE SMEAR, ONE PRIMARY CULTURE, ONE CHARGE PER ORGANISM REQUIRING IDENTIFICATION, AND ONE CHARGE PER SENSITIVITY PERFORMED. This is source specific. Refer to the fee schedule for further clarification, or call Labcorp Indiana, Inc Client Services Department at (574) 236–7263 or (800) 950-7263

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

EVERY patient MUST read, sign, and date:

I request that payment of authorized Medicare or insurance benefits be made on my behalf to the LabCorp Indiana, Inc.

I authorize any holder of medical or other information about me that pertains to the determination of payable benefits for related services to release such information to my designated insurance company and/or Centers of Medicare and Medicaid Services (CMS) and their agents.

I agree that I am fully responsible for the payment of all the designated laboratory services LabCorp Indiana, Inc. rendered to me or on my behalf. I accept responsibility for charges Medicaid does not cover when I am enrolled in a limited coverage Medicaid program.

I understand that additional testing may be performed based on my physician's request. I agree to be fully responsible for payment if my insurance plan does not cover the cost.

I also agree that if any insurance plan, except Medicaid, determines the test(s) requested to be medically unnecessary, and/or uncovered procedure(s), and denies payment to LabCorp Indiana, Inc., I accept full responsibility for payment to LabCorp Indiana, Inc.

_____ Patient Signature

_____ Date