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

MICROBIOLOGY REQUISITION

J.L. Simpson MD
Medical Director

Client Code: ( ) Name: _____

✓ Dr # Physician's Last Name, First Name

[ ] _____ [ ] _____
[ ] _____ [ ] _____
[ ] _____ [ ] _____
[ ] _____ [ ] _____
[ ] _____ [ ] _____
[ ] _____ [ ] _____
[ ] _____ [ ] _____
[ ] _____ [ ] _____

Signature of Ordering Provider

_____
(Signature must be dated, legible, and include first and last name)

Date_____

PATIENT INFORMATION – Please PRINT

Name _____
Last First MI

SS# _____

DOB _____ SEX _____
MO / DAY / YEAR

SPECIMEN COLLECTION

Date _____ Collector's
MO / DAY / YEAR Initials_____

Time:_____ ☐ AM ☐ PM

Fasting ☐ Yes ☐ No

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE
(SEE REVERSE)
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** AND NOTED WITH AN **ASTERISK (*),** THE PATIENT MAY NEED TO SIGN THE ADVANCE BENEFICIARY NOTICE (ABN). REFER TO THE MEDICAL FOUNDATION WEBSITE WW.SBMF.ORG.

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

Copy to Physician(s): Use Complete Name(s)

Current Antibiotic Therapy/Clinical

✓ Test	ICD-10/ Diagnosis
GENITAL	
☐ cervix ☐ penis ☐ vagina ☐ urethra ☐ other_____	
☐ 21086 Bacterial vaginosis smear	
☐ 36350 CHL/GC NAAT (swab)	
☐ 36351 CHL (only) NAAT (swab)	
☐ 36352 GC (only) NAAT (swab)	
☐ 36360 CHL/GC NAAT (first void urine)	
☐ 36362 CHL NAAT (first void urine)	
☐ 36361 GC NAAT (first void urine)	
☐ 36042 Grp B Strep, PCR (vagina/rectum)	
☐ 36043 Grp B Strep, PCR w/ susceptibility testing (use for penicillin allergic patients)	
☐ **36391 HPV, High risk, Thin Prep***	
☐ 36004 HSV 1&2 DNA PCR	
☐ 21027 GC culture (for medico-legal, treatment failure)	
☐ 21042 Ureaplasma/Mycoplasma culture	
☐ 27002 *Trichomonas vaginalis* Antigen	
FECES	
☐ 21002 Feces culture w/ Campylobacter antigen and Shiga toxin antigen by EIA	
☐ 21901 *Campylobacter antigen by EIA*	
☐ 21902 Shiga toxin (E. coli) antigen by EIA	
☐ 36267 *C. difficile* Toxin Gene by NAAT w/Reflex to Toxins A and B by EIA	
☐ 36266 *C. difficile* Toxin Gene by NAAT	
☐ 21261 *H. pylori* antigen	
☐ 21031 VRE culture screen	

✓ Test	ICD-10/ Diagnosis
PARASITOLOGY	
☐ 27006 O&P, Routine, for Cryptosporidium/Giardia antigen	
☐ 27012 O&P, Specified ☐ travel history ☐ immunocompromised patient ☐ suspect parasite other than *Giardia/Cryptosporidium*	
☐ 28085 Cryptosporidium antigens	
☐ 27004 Giardia antigen	
☐ 27018 Parasitology stain for *Cyclospora* and /or *Isospora*	
OTHER SITES	
☐ Abscess ☐ Aspirate ☐ Conjunctiva ☐ Ear, ext ☐ Ear, mid ☐ Tissue ☐ Wound, deep ☐ Wound, superficial ☐ Other _____	
☐ 21049 AFB Culture	
☐ 21023 Fungus Culture	
☐ 21120 Routine culture, aerobic	
☐ 21003 Culture, Anaerobic	
☐ 21192 Culture, Environmental	
RESPIRATORY	
☐ sputum ☐ trach ☐ bronch	
☐ 21049 AFB culture	
☐ 21296 Quantitative bronchial alveolar lavage (BAL)	
☐ 21295 Culture, Respiratory	
☐ 21135 Cystic fibrosis respiratory culture	
☐ 21030 MRSA culture screen (nose)	
☐ 43634 MRSA screen by PCR (nose)	
☐ 36129 Pertussis PCR	
☐ 21023 Fungus culture	

✓ Test	ICD-10/ Diagnosis
RESPIRATORY VIRUS	
☐ nasal wash ☐ nasopharynx ☐ other _____	
☐ 36178 Respiratory Pathogen Panel, PCR	
☐ 36154 Influenza A&B, RSV by PCR	
☐ 50033 Viral Culture, General	
BLOOD/BONE MARROW	
☐ 21015 Blood culture	
☐ 27023 Blood parasite exam	
☐ 21024 Fungus Blood culture	
☐ 47421 AFB culture, Blood/Bone marrow	
THROAT	
☐ 21029 Strep, hemolytic	
☐ 21225 Strep A, antigen, culture	
URINE	
☐ 25075 Urinalysis, with Microscopic	
☐ 25076 Urinalysis, no Microscopic	
☐ 25074 Urinalysis, cult & suscept, if indicated (clean catch/indwelling cath)	
☐ **21054 Urine cult & suscept, if indicated (clean catch/indwelling cath) ***	
☐ 21030 MRSA culture (screen only)	
☐ 21023 Fungus culture	
☐ 21049 AFB culture, urine	

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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