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

CLINICAL EXPANDED REQUISITION

J.L. Simpson MD
Medical Director

Client Code: ( ) **Name:** _____

✓	Dr #	Physician's Last Name, First Name	✓	Dr #	Physician's Last Name, First Name
☐			☐		
☐			☐		
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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 Initials_____
MO / DAY / YEAR

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 WWW.SBMF.ORG

PRIORITY ☐ **Routine** ☐ **Phone** ☐ **STAT** ☐ **Fax #** _____

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

SEE ATTACHED FOR ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

TEST PANELS	DX CODE		DX CODE		DX CODE
☐ **28192 Acute Hep Panel***		☐ **30181 CEA***		☐ 23306 Lead, Blood (Venous)	
☐ 23058 Electrolyte Panel		☐ **29241 Cholesterol, Total***		☐ 23305 Lead, Blood (Capillary)	
☐ 35205 General Health Panel		☐ 28228 C-Reactive Prot (CRP), Quant.		☐ 30096 Luteinizing Hormone (LH)-Serum	
☐ 29525 Hepatic Function Panel		☐ **29227 C-Reactive Prot (CRP-HS), High Sensitive***		☐ 23084 Magnesium	
☐ **29048 Lipid Panel***		☐ 23072 Creatine Phosphokinase (CK) w/MB (if Ind)		☐ **25141 Occult Blood, (Diagnostic)***	
☐ 29526 Metabolic Panel Basic		☐ 23171 Creatine Phosphokinase (CK), Total only		☐ **25140 Occult Blood, (Screening)***	
☐ 29527 Metabolic Panel Comp		☐ 29131 Creatinine		☐ 31082 Phenobarbital	
☐ 35851 Obstetric Panel w/Reflex		☐ 21191 Culture-Autoclave Check		☐ 31081 Phenytoin (Dilantin)	
☐ 29528 Renal Function Panel		☐ **31042 Digoxin***		☐ 29168 Phosphorus	
URINE TEST	DX CODE	☐ 23296 Electrophoresis, Protein w/Interp and reflex to Monoclonal Protein ID		☐ 29127 Potassium	
☐ 29335 Creatinine Clearance		☐ 23057 Electrophoresis, Protein w/Interpretation		☐ 29175 Prealbumin	
☐ 23273 Electrophoresis, Protein w/Interp and Reflex to Monoclonal Protein ID, 24 HR urine		☐ 30085 Estradiol		☐ **30278 Prostate Specific AG, Free & Total***	
☐ 23276 Electrophoresis, Protein w/Interp and Reflex to Monoclonal Protein ID, random urine		☐ **30055 Ferritin***		☐ **25045 Prothrombin Time (INR)***	
☐ 28009 Microalbumin, Quant. Random		☐ 30037 Folate Serum		☐ **30178 PSA (Diagnostic)***	
☐ 28110 Microalbumin, Quant. Urine 24-HR		☐ 30093 FSH (Follicle Stimulating Hormone)		☐ **30078 PSA (Screening)***	
☐ 23318 Total Protein - 24HR Urine		☐ **29242 GGTP***		☐ 30076 PTH (Parathyroid Hormone) Intact	
☐ 25074 UA w/Micro. C&S, (if ind)		☐ 29004 Glucose Challenge, w/50 GM Gestational		☐ 30182 Quantiferon-TB Gold Plus	
☐ 25075 Urinalysis w/Microscopic		☐ **29129 Glucose***		☐ 28019 Rheumatoid Factor (Latex Fixation)	
☐ 25076 Urinalysis w/o Microscopic		☐ 30089 hCG, Qualitative		☐ 28036 Rubella (IGG)	
BLOOD TEST	DX CODE	☐ **30088 hCG, Quantitative***		☐ 25230 Sedimentation Rate	
☐ 22000 ABO and RH Type		☐ 23063 Helicobacter Pylori Urease Breath Test		☐ 29255 SGOT (AST)	
☐ **25039 Activated Partial Thrombo. (APTT)***		☐ **23409 Hemoglobin Aic***		☐ 29152 SGT (ALT)	
☐ 29109 Amylase		☐ 28184 Hepatitis B Surface AB (HBSAB)		☐ 30012 T3, Total	
☐ 28312 Anti-nuclear antibody (ANA) screen		☐ **28183 Hepatitis B Surface Antigen (HBSAG)***		☐ **30213 T4 Total***	
☐ 23203 Bilirubin, Direct		☐ **28194 Hepatitis C Virus (HCV) Antibody***		☐ **30113 T4, Free***	
☐ **23176 Brain-Type Natriuretic Peptide (BNP)***		☐ **25316 Hgb & Hct***		☐ 30009 Testosterone, Free	
☐ 29021 BUN		☐ **28272 HIV Antigen-Antibody Combo, w/Reflex to HIV1/HIV2 Ab Differentiation ***		☐ 30101 Testosterone, Total Only	
☐ **30225 CA125***		☐ **30144 Homocysteine***		☐ **28439 Syphilis Total Antibody w/Reflex to RPR and TP-PA, Serum***	
☐ **30150 CA 27.29***		☐ 28015 Infectious Mononucleosis Screen		☐ **30017 TSH***	
☐ 23026 Calcium, Ionized		☐ 30030 Insulin, Total		☐ 29169 Uric Acid	
☐ 31080 Carbamazepine (Tegretol)		☐ **29100 Iron (include IBC)***		☐ 31032 Valproic Acid (Depakene)	
☐ **25517 CBC w/Differential***		☐ 23129 Lactate Dehydrogenase (LD), Total only		☐ 30041 Vitamin B12	
☐ **25014 CBC w/o Differential***		☐ **28238 Lipoprotein (A)***		☐ Other _____	
		☐ Other _____		☐ Other _____	

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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