

For Lab Use Only	Facility Name	Ordering Physician Name	
	Address	Last	First
	City, State, Zip	Physician NPI No.	
	Phone ()	Report to Fax ()	

Patient Name - Required (Last) (First)		Billing Info <input type="checkbox"/> Copy of Front & Back of Ins. Card Attached	
Location Unique Identifier or MRN		<input type="checkbox"/> Private Ins./PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Inpatient <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Client <input type="checkbox"/> Outpatient	
Patient's Phone Number ()	Collection Date & Time - Required	DOB - Required	Sex M F
Responsible Party (Please Print)		Street Address	
Copy to: First Name Last Name		City, State, Zip	
Address:		Ph. ()	
		Fax ()	
ICD9 Code(s) - REQUIRED INFORMATION			

Each individual test and CMS approved panel must have ICD-9 code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD-9 codes for the tests ordered. @ Tests for Medicare patients must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests.

TEST	SPECIMEN TYPE	TEST	SPECIMEN TYPE
<input type="checkbox"/> Activated Protein C Resistance Assay	APC *	<input type="checkbox"/> Factor XIII Screen	FACT 13 *
<input type="checkbox"/> ADAMTS-13 Activity & Antigen	ADAM13 *	<input type="checkbox"/> Fibrin Degradation Products (FDP, FSP, Fibrin)	FDP *
<input type="checkbox"/> Alpha-2 Antiplasmin	ALPHA2 *	<input type="checkbox"/> Heparin Concentration (unfractionated hep.)	HEPAR *
<input type="checkbox"/> Anti-Phospholipid Ab	APHSAB *	<input type="checkbox"/> Heparin Xa (Fondaparinux), Plasma	ARIX *
<input type="checkbox"/> Anticardiolipin Antibodies	ACA *	<input type="checkbox"/> Heparin Xa (LMWH), Plasma	ANTIXA *
<input type="checkbox"/> Antithrombin III	AT3 *	<input type="checkbox"/> Heparin Platelet Factor 4 Antibody	HITAB ▲
<input type="checkbox"/> D-Dimer	DDIM *	<input type="checkbox"/> Heparin-Induced Platelet Aggregation	HIPA ▲
<input type="checkbox"/> D-Dimer, ELISA	DDIML *	<input type="checkbox"/> Lupus Anticoagulant (if positive, a Platelet Neutralization is done) @	LUPUS *
<input type="checkbox"/> Dilute Russell Viper Venom Time	DRVVTP *	<input type="checkbox"/> Plasminogen	PLASMIN *
<input type="checkbox"/> Euglobulin Clot Lysis	ECL *	<input type="checkbox"/> Protein C, Activity (functional)	PROTC *
<input type="checkbox"/> Factor II	FACT2 *	<input type="checkbox"/> Protein C, Antigen, Total	TOTALC *
<input type="checkbox"/> Factor IX	FACT9 *	<input type="checkbox"/> Protein S, Activity (functional)	PROTS *
<input type="checkbox"/> Factor V	FACT5 *	<input type="checkbox"/> Protein S, Antigen, Total	TOTALS *
<input type="checkbox"/> Factor VII	FACT7 *	<input type="checkbox"/> Free Protein S, Activity, Plasma	PROTSF *
<input type="checkbox"/> Factor VII	FACT7 *	<input type="checkbox"/> PT Inhibitor Screen @	PTINH *
<input type="checkbox"/> Factor VIII	FACT8 *	<input type="checkbox"/> PTT Inhibitor Screen (if positive, a Platelet Neutralization is done)@	PTTINH *
<input type="checkbox"/> Factor VIII Inhibitor	F8INH *	<input type="checkbox"/> Reptilase Time	REPT *
<input type="checkbox"/> Factor X	FACT10 *	<input type="checkbox"/> Ritocetin Co-Factor	RIST *
<input type="checkbox"/> Factor XI	FACT11 *	<input type="checkbox"/> Thrombin Time	TT *
		<input type="checkbox"/> Von Willebrand Antigen	VWAG *

MOLECULAR PATHOLOGY		
<input type="checkbox"/> Methylene-tetrahydrofolate Reductase (MTHFR)	MTHFR	L
<input type="checkbox"/> Factor II, Prothrombin-20210A Mutation	P20210	L
<input type="checkbox"/> Factor V Leiden	LEID	L

SPECIAL CHEMISTRY		
<input type="checkbox"/> Celiac Disease Screen	CDAS	S
Components may be ordered individually-see second page for components		

SPECIMEN TYPE

* = Frozen, Platelet Poor Plasma

L = Lavender top (EDTA) tube, Room Temp

▲ = Frozen - Serum, Red-top tube; allow 1 hr to clot before spinning

S = Serum, Refrigerate - SST

Celiac Disease Screen: Test Code: **CDAS**

Components may be ordered individually:

IgA Anti TTG

Test Code: **ATTG**

IgG Anti-DGP

Test Code: **GDGP**

If Shipping on Friday, check for Saturday delivery

Fax delivery notification to: (650) 724-4758

SHIP TO: Stanford's Pathology and Clinical Laboratory
Attn: Specimen Processing
3375 Hillview Avenue
Palo Alto, CA 94304
Phone: 1(877) 717-3733

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

Patient's First Name: _____

Last Name: _____

Patient's MRN: _____

Or Affix Label Here

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for laboratory test(s) below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the laboratory test(s) below.

Laboratory test(s)	Reason Medicare May Not Pay:	Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the laboratory test(s) listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the laboratory test(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the laboratory test(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the laboratory test(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____

Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.