



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

Patient Name (Last) (First)	Insurance Info: Attach a copy of front & back of Insurance card or face sheet <input type="checkbox"/> Private Ins/PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Patient <input type="checkbox"/> Client
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Client Acct # Unique ID or MRN	DOB-Required	Sex M F	Responsible Party ( Please Print)
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Patient's Phone Number ( )	Collection Date & Time	Collection by- Required	Address
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Copy to: First Name Last Name	City, State, Zip
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Copy to complete address for mailing:	ICD9 Code(s) - REQUIRED INFORMATION
	Physician Signature: Date:

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.

Special Coagulation	Specimen Type	Special Coagulation	Specimen Type
<input type="checkbox"/> Activated Protein C Resistance Assay	APC *	<input type="checkbox"/> Factor XIII Screen	FACT 13 *
<input type="checkbox"/> ADAMTS-13 Profile, Activity & Inhibitor	ADAMTS *	<input type="checkbox"/> Unfractionated Heparin Activity by Anti-Xa Activity	HEPAR *
<input type="checkbox"/> Alpha-2 Antiplasmin	ALPHA2 *	<input type="checkbox"/> Arixtra (Fondaparinux)	ARIX *
<input type="checkbox"/> Anti-Phospholipid Ab Panel	APHSAB *	<input type="checkbox"/> LMWH Activity by Anti-Xa Activity	ANTIXA *
<input type="checkbox"/> Cardiolipin Ab, IgG & IgM, Serum	ACA R	<input type="checkbox"/> Heparin Platelet Factor 4 Antibody	HITAB ▼
<input type="checkbox"/> Antithrombin III, Activity	AT3 *	<input type="checkbox"/> Heparin-Induced Platelet Aggregation	HIPA ▼
<input type="checkbox"/> Dilute Russell Viper Venom Time	DRVVTP *	<input type="checkbox"/> Lupus Anticoagulant (if positive, a Platelet Neutralization is done) @	LUPUS *
<input type="checkbox"/> Euglobulin Clot Lysis	ECL *	<input type="checkbox"/> Plasminogen	PLASMN *
<input type="checkbox"/> Factor II	FACT2 *	<input type="checkbox"/> Protein C, Activity (functional)	PROTC *
<input type="checkbox"/> Factor IX	FACT9 *	<input type="checkbox"/> Protein C, Antigen, Total	TOTALC *
<input type="checkbox"/> Factor V	FACT5 *	<input type="checkbox"/> Protein S, Activity (functional)	PROTS *
<input type="checkbox"/> Factor VII	FACT7 *	<input type="checkbox"/> Protein S, Antigen, Total	TOTALS *
<input type="checkbox"/> Factor VIII	FACT8 *	<input type="checkbox"/> Free Protein S	PROTSF *
<input type="checkbox"/> Factor VIII Inhibitor	F8INH *	<input type="checkbox"/> PT Inhibitor Screen @	PTINH *
<input type="checkbox"/> Factor X	FACT10 *	<input type="checkbox"/> PTT Inhibitor Screen (if positive, a Platelet Neutralization is done) @	PTTINH *
<input type="checkbox"/> Factor XI	FACT11 *	<input type="checkbox"/> Ritocetin Co-Factor	RIST *
<input type="checkbox"/> Factor XII	FACT12 *	<input type="checkbox"/> Von Willebrand Antigen	VWAG *

Molecular Pathology	Specimen Type	Special Chemistry	Specimen Type
<input type="checkbox"/> Methylene-tetrahydrofolate Reductase	MTHFR L	<input type="checkbox"/> Celiac Disease Screen	CDAS S
<input type="checkbox"/> Factor II, Prothrombin-20210A Mutation	P20210 L	<input type="checkbox"/> Leflunomide Metabolite	LEF R
<input type="checkbox"/> Factor V Leiden	LEID L		

**Specimen Type**  
 \* = Frozen, Platelet Poor Plasma    ▼ = Frozen - Serum, Red-top tube; allow 1 hr to clot before spinning  
 S = Serum, Refrigerate – SST    R = Red-top tube (Plain) no additive    L = Lavender top (EDTA) tube, Room Temp

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

**Components may be ordered individually:**

IgA Anti TTG Test Code: **ATTG**

IgG Anti-DGP Test Code: **GDGP**

Ship to:

Stanford's Anatomic Pathology and Clinical Laboratory

Attn: Specimen Processing

3375 Hillview Ave

Palo Alto, CA 94304

Phone: 1 (877) 717-3733

**If shipping Friday check for Saturday delivery**

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: \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_

Patient's MRN: \_\_\_\_\_

Or Affix Label Here



**STANFORD**  
UNIVERSITY  
MEDICAL CENTER  
Clinical Laboratories  
3375 Hillview Avenue  
Palo Alto, CA 94304  
(877) 717-3733

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D.** 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 **D.** below.

D.	E. Reason Medicare May Not Pay:	F. 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 **D.** 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.

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

- OPTION 1.** I want the **D.** 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 **D.** 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 **D.** listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

### H. 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.

<b>I. Signature:</b>	<b>J. Date:</b>

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.