

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	
CSN -	DOB - Required	Sex M F	
Patient's Phone Number ()	Collection Date & Time - Required	Collected By - Required	
Copy to: First Name Last Name		Responsible Party (Please Print)	
Address:		Street Address	
Ph. ()		City, State, Zip	
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 document **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 should be provided to the patient if there is a reason to believe Medicare will not pay for the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests.

Specimen Remark (SREQ):	Last HIV Viral Load: _____ copies/mL	Test Date: _____
<input type="checkbox"/> HIV-1 Quantitative, PCR, EDTA Plasma @		HIVPCR *
<input type="checkbox"/> HIV-1 Drug Mutation Analysis, Genotype, EDTA Plasma		AVRT *
<input type="checkbox"/> HIV-1 Genotype with Virtual Phenotype, EDTA Plasma		AVRT, AVRTV *
<input type="checkbox"/> HIV-1 Antiviral Resistance Testing - Integrase, EDTA Plasma		AVIN *
<input type="checkbox"/> CD4/CD8 Panel, Whole Blood Lavender-top tube (EDTA)		C4C8
<input type="checkbox"/> Hepatitis B Quantitative, PCR, Serum Gold-top SST tube		HBPCR ∅
<input type="checkbox"/> Hepatitis C Quantitative, PCR, Serum Gold-top SST tube		HCVPCR ∅
<input type="checkbox"/> Hepatitis C Virus (HCV) Genotype, Serum Gold-top SST tube		HCVGE ∅
<input type="checkbox"/> EBV by PCR, Quantitative, Lavender-top tube (EDTA)		EBVPCR ▲
<input type="checkbox"/> Cytomegalovirus Qualitative, PCR, Non Blood Broncho-Alveolar Lavage (BAL), Fluids (Non-Blood) in sterile leak-proof container or tube, Tissue in Viral transport media (VTM). Bone Marrow in a Blue-top tube (Sodium Citrate) or Yellow-top tube (ACD)		CMVQL ▲
<input type="checkbox"/> Cytomegalovirus Quantitative, PCR, Plasma from a Yellow-top tube (ACD) Solution A		CMVQT ■
<input type="checkbox"/> Herpes Simplex Virus (HSV) PCR, CSF in a sterile leak-proof container or tube		HSVPCR

***Centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is going to be greater than 3 days, freeze plasma and transport frozen.**

■ Centrifuge and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 3 days, freeze and transport frozen.

∅ Centrifuge and transfer serum to a screw-capped tube. Transport refrigerated. If transport is greater than 3 days, freeze and transport frozen.

▲ Refrigerate

SHIP TO:	Stanford's Pathology and Clinical Laboratory Attn: Specimen Processing 3375 Hillview Avenue Palo Alto, CA 94304 Phone: 1(877) 717-3733
If Shipping on Friday, check for Saturday delivery	
Fax delivery notification to: (650) 724-4758	
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.