## ▼ PHYSICIAN INFORMATION ▼

Physician Name
Address
City, State, Zip
Phone No. / Fax No.
UPIN #

NURSING HOMES ☐ SKILLED ☐ NON-SKILLED FACILITY NAME _____ PHONE _____

New Hanover Regional Medical Center

☐ New Hanover Regional Medical Center
Medical Mall
2289 S. 17th Street
Wilmington, NC 28402
(910) 815-5100 Fax (910) 815-5032

☐ Cape Fear Hospital Laboratory
5301 Wrightsville Avenue
Wilmington, NC 28403
(910) 452-8171 Fax (910) 452-8273

☐ New Hanover Regional Medical Center
Military Cutoff Diagnostic Center
1135 Military Cutoff Road
Wilmington, NC 28405
(910) 256-7997

## Patient Information

| Last Name | First Name | MI | Maiden |
|---|---|---|---|
| | | | |

| Last Four Digits of SSN# | Birthdate | Sex ☐ M ☐ F |
|---|---|---|
| | | |

| Phone No. | Race | Marital Status M S D X W |
|---|---|---|
| | | |

## Responsible Party Information (Must be completed only if submitting specimen)

| Last Name (if not the patient) | First Name (if not the patient) | MI |
|---|---|---|
| | | |

| Last Four Digits of SSN# (if not the patient) | Patient's Relationship to Responsible Party ☐ Self ☐ Child ☐ Spouse ☐ Other |
|---|---|
| | |

| Street Address | Phone No. (if not the patient) |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Employer Name | Employer Phone No. |
|---|---|
| | |

| Employer Address | Date Retired |
|---|---|
| | |

## Medical Necessity Information

Sign, Symptom, diagnosis or ICD9 Info required on all tests ordered.

| Narrative Diagnosis | ICD9 Codes |
|---|---|
| 1. _____ | |
| 2. _____ | |
| 3. _____ | |
| 4. _____ | |

ABN Signed? ☐ Yes ☐ No

## Billing Information (Must be completed only if submitting specimen)

**Please attach a copy of all Insurance I.D. Cards - Front and Back**

**Bill to:** ☐ Physician/Client ☐ Insurance ☐ Medicare ☐ Part A ☐ Part B ☐ Patient ☐ Medicaid

Medicare Secondary Questionnaire Completed? ☐ Yes ☐ No

| Medicare Number | Medicaid Number |
|---|---|
| | |

**Primary Insurance**

| Primary Insurance Company Name | Phone No. |
|---|---|
| | |

| Company Address | |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Policy Number | Group Number |
|---|---|
| | |

| Group Name | Benefit Code |
|---|---|
| | |

| Insured Name | Relationship |
|---|---|
| | |

**Secondary Insurance**

| Secondary Insurance Company Name | Phone No. |
|---|---|
| | |

| Company Address | |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Policy Number | Group Number |
|---|---|
| | |

| Group Name | Benefit Code |
|---|---|
| | |

| Insured Name | Relationship |
|---|---|
| | |

## Specimen Information

**STAT** ☐ Phone( ) _____ ☐ Fax ( ) _____ ☐ Do not call after hours Collected by

Date Drawn / / Time Drawn A.M. P.M. ☐ Fasting ☐ Random 24 Hour Urine Volume Time of Last Dose A.M. P.M.

| CPT | ✓ | Tests or Panels (Panel or Single Tests may be selected) |
|---|---|---|
| **80051** | | **Electrolytes Panel** |
| 84295 | | Sodium (Na) |
| 84132 | | Potassium (K) |
| 82435 | | Chloride (Cl) |
| 82374 | | Carbon Dioxide ($CO_2$) |
| **80048** | | **Basic Metabolic Panel** |
| 80051 | | Electrolyte Panel |
| 84520 | | BUN |
| 82565 | | Creatinine |
| 82947 | | Glucose |
| 82310 | | Calcium |
| **80053** | | **Comprehensive Metabolic Panel** |
| 80048 | | Basic Metabolic Panel |
| 82040 | | Albumin |
| 84075 | | Alkaline Phos. |
| 82247 | | Bilirubin, Total |
| 84450 | | AST / SGOT |
| 84460 | | ALT / SGPT |
| 84155 | | Total Protein |
| **80076** | | **Hepatic Function Panel** |
| 82040 | | Albumin |
| 82247 | | Bilirubin, Total |
| 82248 | | Bilirubin, Direct (conjugated) |
| 84450 | | AST / SGOT |
| 84460 | | ALT / SGPT |
| 84075 | | Alkaline Phos. |
| 84155 | | Total Protein |

| CPT | ✓ | Tests or Panels (Panel or Single Tests may be selected) |
|---|---|---|
| | | **Qualitative Urine Test for Drugs of Abuse** |
| 80101 | | Amphetamine (U) Qual |
| 80101 | | Barbiturates (U) Qual |
| 80101 | | Benzodiazepine (U) Qual |
| 80101 | | Cocaine (U) Qual |
| 80101 | | Methadone (U) Qual |
| 80101 | | Opiates (U) Qual |
| 80101 | | PCP (U) Qual |
| 80101 | | TCA (U) Qual |
| 80101 | | THC (U) Qual |
| **80069** | | **Renal Funct. Panel** |
| 80048 | | Basic Metabolic Panel |
| 82040 | | Albumin |
| 84100 | | Phosphorus |
| | | **Single Hepatitis Tests** |
| 86709 | | Hepatitis A Antibody IGM |
| 87340 | | Hepatitis B Surface Antigen |
| 86706 | | Hepatitis B Surface Antibody |
| 86704 | | Hepatitis B Core Antibody Total |
| 86803 | | Hepatitis C Antibody |

| CPT | ✓ | Tests |
|---|---|---|
| | | **Core Lab** |
| 89051 | | Body Fluid Cell Count With Differential |
| | | Specimen Source _____ |
| 85018/ 85014 | | ☐ Hemoglobin ☐ Hematocrit |
| 85027 | | CBC with platelets without differential |
| 85025 | | CBC with platelets with auto-differential |
| 85027/ 85007 | | CBC with platelets with manual differential |
| 85652 | | ESR Sedimentation Rate |
| 85610 | | PT with INR anticoagulant ____ |
| 85730 | | PTT anticoagulant ____ |
| 81001 | | Urinalysis with sediment microscopic |
| 81003 | | Urinalysis without sediment microscopic |
| 84703 | | Pregnancy Test (☐ Serum ☐ Urine) |
| 84702 | | Quantitative HCG |
| 82150 | | Amylase |
| 82670 | | Estradiol |
| 83690 | | Lipase |
| 83735 | | Magnesium |
| 84144 | | Progesterone |
| 84153 | | PSA Screen |
| 84439 | | FT4 |
| 84443 | | TSH |

| CPT | ✓ | Single Tests |
|---|---|---|
| | | **Transfusion Medicine** |
| 86900 | | Blood typing ABO |
| 86901 | | Blood typing RH |
| 86850 | | Antibody Screen (IDC) |
| 86870 | | Antibody Identification |
| 86920 | | Crossmatch _____ units PRBC |
| 86880 | | Direct Coombs |
| 86850 | | Indirect Coombs Qualitative |
| | | Transfuse Rhogam |
| 86886 | | Antibody Titer |
| 86905 | | Antigen Type (patient) |
| | | **Single Tests** |
| 86038 | | Antinuclear Antibody (ANA) Screen |
| 83036 | | Hemoglobin A1C |
| 86703 | | HIV Screen |
| 86308 | | MONO Test |
| 86592 | | RPR Screen |
| 86762 | | Rubella Antibody IgG |
| 82950 | | 1 Hour GTT___ |
| 83605 | | Lactate (lactic acid) |
| 84165 | | Serum Protein Electrophoresis |
| 84155 | | Urine Protein Electrophoresis |

| CPT | ✓ | Single Tests |
|---|---|---|
| | | **Microbiology** |
| 87088 | | Urine Culture |
| 87045/ 87046 | | Feces (stool) Culture |
| source | | Routine Culture (other) **must** specify specimen source _____ |
| 87040 | | Blood Culture |
| 87116/ 87015 | | AFB Culture specimen source _____ |
| 87102 | | Fungus Culture specimen source _____ |
| 87254 | | Virus Culture specimen source _____ |
| 87254 | | Herpes Culture specimen source _____ |
| | | Rapid Strep Antigen Screen |
| | | Rotavirus Antigen |
| 87420 | | RSV Antigen |
| 89055 | | Stool for WBC's |

| CPT | ✓ | Molecular Pathology |
|---|---|---|
| | | **Flow Cytometry Protocol Studies** |
| 88184 | | ☐ Leukemia/Lymphoma Study |
| 88185 | | • NOTE: If correlating morphology is not available, a White Cell Count with Differential will be performed and billed. |
| 86361 | | ☐ **CD4** Helper T-Cells |
| | | • NOTE: If correlating morphology is not available, a White Cell Count with Differential will be performed and billed. |
| | | **Molecular Protocol Studies** |
| 87536 | | ☐ HIV-1 RNA QN bDNA (V3.0) |
| 87491 | | ☐ Chlamydia Trachomatis by PCR |
| 87591 | | ☐ **Neisseria Gonorrhoeae by PCR** |
| | | **Molecular Protocols For Referral Lab** |
| | | ☐ FISH |
| | | ☐ Cytogenetics |
| | | ☐ Southern Blot |
| | | ☐ Polymerase Chain Reaction (PCR) |
| | | **Specimen** |
| | | ☐ Peripheral Blood |
| | | ☐ Bone Marrow Aspirate |
| | | ☐ Cerebral Spinal Fluid |
| | | ☐ Effusion, Source _____ |
| | | ☐ FNA, Site _____ |
| | | ☐ Fresh Tissue, Type & Site _____ |
| | | ☐ Paraffin Block, Site & Block # ____ |
| | | ☐ Slides, Site & Accession# _____ |

**Other test required. Write complete test name legibly. Other information related to test(s) requested.**

Only tests or Medicare Approved Panels that are medically necessary for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. Screening tests will not be reimbursed and should not be submitted for payment. The OIG states that a physician who orders medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the False Claims Act.

**Physician Signature (required)** Date/Time

**THIS FORM PART OF PERMANENT MEDICAL RECORD**

*0642*

ORIGINAL - LABORATORY YELLOW - PATIENT PINK - PHYSICIAN

# OutPatient Requisition

LA-104 (12/10 v.15)

## ▼ PHYSICIAN INFORMATION ▼

Physician Name
Address
City, State, Zip
Phone No. / Fax No.
UPIN #

NURSING HOMES ☐ SKILLED ☐ NON-SKILLED FACILITY NAME _____ PHONE _____

New Hanover Regional Medical Center

☐ New Hanover Regional Medical Center
Medical Mall
2289 S. 17th Street
Wilmington, NC 28402
(910) 815-5100 Fax (910) 815-5032

☐ Cape Fear Hospital Laboratory
5301 Wrightsville Avenue
Wilmington, NC 28403
(910) 452-8171 Fax (910) 452-8273

☐ New Hanover Regional Medical Center
Military Cutoff Diagnostic Center
1135 Military Cutoff Road
Wilmington, NC 28405
(910) 256-7997

## Patient Information

| Last Name | First Name | MI | Maiden |
|---|---|---|---|
| | | | |

| Last Four Digits of SSN# | Birthdate | Sex ☐ M ☐ F |
|---|---|---|
| | | |

| Phone No. | Race | Marital Status M S D X W |
|---|---|---|
| | | |

## Responsible Party Information (Must be completed only if submitting specimen)

| Last Name (if not the patient) | First Name (if not the patient) | MI |
|---|---|---|
| | | |

| Last Four Digits of SSN# (if not the patient) | Patient's Relationship to Responsible Party ☐ Self ☐ Child ☐ Spouse ☐ Other |
|---|---|
| | |

| Street Address | Phone No. (if not the patient) |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Employer Name | Employer Phone No. |
|---|---|
| | |

| Employer Address | Date Retired |
|---|---|
| | |

## Medical Necessity Information

Sign, Symptom, diagnosis or ICD9 Info required on all tests ordered.

| Narrative Diagnosis | ICD9 Codes |
|---|---|
| 1. _____ | |
| 2. _____ | |
| 3. _____ | |
| 4. _____ | |

ABN Signed? ☐ Yes ☐ No

## Billing Information (Must be completed only if submitting specimen)

**Please attach a copy of all Insurance I.D. Cards - Front and Back**

**Bill to:** ☐ Physician/Client ☐ Insurance ☐ Medicare ☐ Part A ☐ Part B ☐ Patient ☐ Medicaid

Medicare Secondary Questionnaire Completed? ☐ Yes ☐ No

| Medicare Number | Medicaid Number |
|---|---|
| | |

### Primary Insurance

| Primary Insurance Company Name | Phone No. |
|---|---|
| | |

| Company Address | |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Policy Number | Group Number |
|---|---|
| | |

| Group Name | Benefit Code |
|---|---|
| | |

| Insured Name | Relationship |
|---|---|
| | |

### Secondary Insurance

| Secondary Insurance Company Name | Phone No. |
|---|---|
| | |

| Company Address | |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Policy Number | Group Number |
|---|---|
| | |

| Group Name | Benefit Code |
|---|---|
| | |

| Insured Name | Relationship |
|---|---|
| | |

## Specimen Information

**STAT** ☐ Phone( ) _____ ☐ Fax ( ) _____ ☐ Do not call after hours Collected by

Date Drawn / / Time Drawn A.M. P.M. ☐ Fasting ☐ Random 24 Hour Urine Volume Time of Last Dose A.M. P.M.

| CPT | ✓ | Tests or Panels (Panel or Single Tests may be selected) |
|---|---|---|
| **80051** | | **Electrolytes Panel** |
| 84295 | | Sodium (Na) |
| 84132 | | Potassium (K) |
| 82435 | | Chloride (Cl) |
| 82374 | | Carbon Dioxide ($CO_2$) |
| **80048** | | **Basic Metabolic Panel** |
| 80051 | | Electrolyte Panel |
| 84520 | | BUN |
| 82565 | | Creatinine |
| 82947 | | Glucose |
| 82310 | | Calcium |
| **80053** | | **Comprehensive Metabolic Panel** |
| 80048 | | Basic Metabolic Panel |
| 82040 | | Albumin |
| 84075 | | Alkaline Phos. |
| 82247 | | Bilirubin, Total |
| 84450 | | AST / SGOT |
| 84460 | | ALT / SGPT |
| 84155 | | Total Protein |
| **80076** | | **Hepatic Function Panel** |
| 82040 | | Albumin |
| 82247 | | Bilirubin, Total |
| 82248 | | Bilirubin, Direct (conjugated) |
| 84450 | | AST / SGOT |
| 84460 | | ALT / SGPT |
| 84075 | | Alkaline Phos. |
| 84155 | | Total Protein |

| CPT | ✓ | Tests or Panels (Panel or Single Tests may be selected) |
|---|---|---|
| **80069** | | **Renal Funct. Panel** |
| 80048 | | Basic Metabolic Panel |
| 82040 | | Albumin |
| 84100 | | Phosphorus |
| | | **Single Hepatitis Tests** |
| 86709 | | Hepatitis A Antibody IGM |
| 87340 | | Hepatitis B Surface Antigen |
| 86706 | | Hepatitis B Surface Antibody |
| 86704 | | Hepatitis B Core Antibody Total |
| 86803 | | Hepatitis C Antibody |

| CPT | ✓ | Tests |
|---|---|---|
| | | **Core Lab** |
| 89051 | | Body Fluid Cell Count With Differential |
| | | Specimen Source _____ |
| 85018/ 85014 | | ☐ Hemoglobin ☐ Hematocrit |
| 85027 | | CBC with platelets without differential |
| 85025 | | CBC with platelets with auto-differential |
| 85027/ 85007 | | CBC with platelets with manual differential |
| 85652 | | ESR Sedimentation Rate |
| 85610 | | PT with INR anticoagulant ____ |
| 85730 | | PTT anticoagulant ____ |
| 81001 | | Urinalysis with sediment microscopic |
| 81003 | | Urinalysis without sediment microscopic |
| 84703 | | Pregnancy Test (☐ Serum ☐ Urine) |
| 84702 | | Quantitative HCG |
| 82150 | | Amylase |
| 82670 | | Estradiol |
| 83690 | | Lipase |
| 83735 | | Magnesium |
| 84144 | | Progesterone |
| 84153 | | PSA Screen |
| 84439 | | FT4 |
| 84443 | | TSH |

| CPT | ✓ | Single Tests |
|---|---|---|
| | | **Transfusion Medicine** |
| 86900 | | Blood typing ABO |
| 86901 | | Blood typing RH |
| 86850 | | Antibody Screen (IDC) |
| 86870 | | Antibody Identification |
| 86920 | | Crossmatch _____ units PRBC |
| 86880 | | Direct Coombs |
| 86850 | | Indirect Coombs Qualitative |
| | | Transfuse Rhogam |
| 86886 | | Antibody Titer |
| 86905 | | Antigen Type (patient) |
| | | **Single Tests** |
| 86038 | | Antinuclear Antibody (ANA) Screen |
| 83036 | | Hemoglobin A1C |
| 86703 | | HIV Screen |
| 86308 | | MONO Test |
| 86592 | | RPR Screen |
| 86762 | | Rubella Antibody IgG |
| 82950 | | 1 Hour GTT___ |
| 84165 | | Serum Protein Electrophoresis |
| 84155 | | Urine Protein Electrophoresis |

| CPT | ✓ | Single Tests |
|---|---|---|
| | | **Microbiology** |
| 87088 | | Urine Culture |
| 87045/ 87046 | | Feces (stool) Culture |
| source | | Routine Culture (other) **must** specify specimen source _____ |
| 87040 | | Blood Culture |
| 87050 | | AFB Culture specimen source _____ |
| 87102 | | Fungus Culture specimen source _____ |
| 87254 | | Virus Culture specimen source _____ |
| 87254 | | Herpes Culture specimen source _____ |
| | | Rapid Strep Antigen Screen |
| | | Rotavirus Antigen |
| 87420 | | RSV Antigen |
| 89055 | | Stool for WBC's |

| CPT | ✓ | Molecular Pathology |
|---|---|---|
| | | **Flow Cytometry Protocol Studies** |
| 88184 | | ☐ Leukemia/Lymphoma Study |
| 88185 | | • NOTE: If correlating morphology is not available, a White Cell Count with Differential will be performed and billed. |
| 86361 | | ☐ **CD4** Helper T-Cells |
| | | • NOTE: If correlating morphology is not available, a White Cell Count with Differential will be performed and billed. |
| | | **Molecular Protocol Studies** |
| 87536 | | ☐ HIV-1 RNA QN bDNA (V3.0) |
| 87491 | | ☐ Chlamydia Trachomatis by PCR |
| 87591 | | ☐ **Neisseria Gonorrhoeae by PCR** |
| | | **Molecular Protocols For Referral Lab** |
| | | ☐ FISH |
| | | ☐ Cytogenetics |
| | | ☐ Southern Blot |
| | | ☐ Polymerase Chain Reaction (PCR) |
| | | **Specimen** |
| | | ☐ Peripheral Blood |
| | | ☐ Bone Marrow Aspirate |
| | | ☐ Cerebral Spinal Fluid |
| | | ☐ Effusion, Source _____ |
| | | ☐ FNA, Site _____ |
| | | ☐ Fresh Tissue, Type & Site _____ |
| | | ☐ Paraffin Block, Site & Block # _____ |
| | | ☐ Slides, Site & Accession# _____ |

**Other test required. Write complete test name legibly. Other information related to test(s) requested.**

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**Physician Signature (required)** Date/Time

**THIS FORM PART OF PERMANENT MEDICAL RECORD**

*0642*

ORIGINAL - LABORATORY YELLOW - PATIENT PINK - PHYSICIAN

# OutPatient Requisition

LA-104 (12/10 v.15)

## ▼ PHYSICIAN INFORMATION ▼

Physician Name
Address
City, State, Zip
Phone No. / Fax No.
UPIN #

NURSING HOMES ☐ SKILLED ☐ NON-SKILLED FACILITY NAME _____ PHONE _____

New Hanover Regional Medical Center

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1135 Military Cutoff Road
Wilmington, NC 28405
(910) 256-7997

## Patient Information

| Last Name | First Name | MI | Maiden |
|---|---|---|---|
| | | | |

| Last Four Digits of SSN# | Birthdate | Sex ☐ M ☐ F |
|---|---|---|
| | | |

| Phone No. | Race | Marital Status M S D X W |
|---|---|---|
| | | |

## Responsible Party Information (Must be completed only if submitting specimen)

| Last Name (if not the patient) | First Name (if not the patient) | MI |
|---|---|---|
| | | |

| Last Four Digits of SSN# (if not the patient) | Patient's Relationship to Responsible Party ☐ Self ☐ Child ☐ Spouse ☐ Other |
|---|---|
| | |

| Street Address | Phone No. (if not the patient) |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Employer Name | Employer Phone No. |
|---|---|
| | |

| Employer Address | Date Retired |
|---|---|
| | |

## Medical Necessity Information

Sign, Symptom, diagnosis or ICD9 Info required on all tests ordered.

| Narrative Diagnosis | ICD9 Codes |
|---|---|
| 1. _____ | |
| 2. _____ | |
| 3. _____ | |
| 4. _____ | |

ABN Signed? ☐ Yes ☐ No

## Billing Information (Must be completed only if submitting specimen)

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**Bill to:** ☐ Physician/Client ☐ Insurance ☐ Medicare ☐ Part A ☐ Part B ☐ Patient ☐ Medicaid

Medicare Secondary Questionnaire Completed? ☐ Yes ☐ No

| Medicare Number | Medicaid Number |
|---|---|
| | |

### Primary Insurance

| Primary Insurance Company Name | Phone No. |
|---|---|
| | |

| Company Address | |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Policy Number | Group Number |
|---|---|
| | |

| Group Name | Benefit Code |
|---|---|
| | |

| Insured Name | Relationship |
|---|---|
| | |

### Secondary Insurance

| Secondary Insurance Company Name | Phone No. |
|---|---|
| | |

| Company Address | |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

| Policy Number | Group Number |
|---|---|
| | |

| Group Name | Benefit Code |
|---|---|
| | |

| Insured Name | Relationship |
|---|---|
| | |

## Specimen Information

**STAT** ☐ Phone( ) _____ ☐ Fax ( ) _____ ☐ Do not call after hours Collected by

Date Drawn / / Time Drawn A.M. P.M. ☐ Fasting ☐ Random 24 Hour Urine Volume Time of Last Dose A.M. P.M.

| CPT | ✓ | Tests or Panels (Panel or Single Tests may be selected) |
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| 84132 | | Potassium (K) |
| 82435 | | Chloride (Cl) |
| 82374 | | Carbon Dioxide ($CO_2$) |
| **80048** | | **Basic Metabolic Panel** |
| 80051 | | Electrolyte Panel |
| 84520 | | BUN |
| 82565 | | Creatinine |
| 82947 | | Glucose |
| 82310 | | Calcium |
| **80053** | | **Comprehensive Metabolic Panel** |
| 80048 | | Basic Metabolic Panel |
| 82040 | | Albumin |
| 84075 | | Alkaline Phos. |
| 82247 | | Bilirubin, Total |
| 84450 | | AST / SGOT |
| 84460 | | ALT / SGPT |
| 84155 | | Total Protein |
| **80076** | | **Hepatic Function Panel** |
| 82040 | | Albumin |
| 82247 | | Bilirubin, Total |
| 82248 | | Bilirubin, Direct (conjugated) |
| 84450 | | AST / SGOT |
| 84460 | | ALT / SGPT |
| 84075 | | Alkaline Phos. |
| 84155 | | Total Protein |

| CPT | ✓ | Tests or Panels (Panel or Single Tests may be selected) |
|---|---|---|
| **80069** | | **Renal Funct. Panel** |
| 80048 | | Basic Metabolic Panel |
| 82040 | | Albumin |
| 84100 | | Phosphorus |
| | | **Single Hepatitis Tests** |
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| 87340 | | Hepatitis B Surface Antigen |
| 86706 | | Hepatitis B Surface Antibody |
| 86704 | | Hepatitis B Core Antibody Total |
| 86803 | | Hepatitis C Antibody |

| CPT | ✓ | Tests |
|---|---|---|
| | | **Core Lab** |
| 89051 | | Body Fluid Cell Count With Differential |
| | | Specimen Source _____ |
| 85018/ 85014 | | ☐ Hemoglobin ☐ Hematocrit |
| 85027 | | CBC with platelets without differential |
| 85025 | | CBC with platelets with auto-differential |
| 85027/ 85007 | | CBC with platelets with manual differential |
| 85652 | | ESR Sedimentation Rate |
| 85610 | | PT with INR anticoagulant ____ |
| 85730 | | PTT anticoagulant ____ |
| 81001 | | Urinalysis with sediment microscopic |
| 81003 | | Urinalysis without sediment microscopic |
| 84703 | | Pregnancy Test (☐ Serum ☐ Urine) |
| 84702 | | Quantitative HCG |
| 82150 | | Amylase |
| 82670 | | Estradiol |
| 83690 | | Lipase |
| 83735 | | Magnesium |
| 84144 | | Progesterone |
| 84153 | | PSA Screen |
| 84439 | | FT4 |
| 84443 | | TSH |

| CPT | ✓ | Single Tests |
|---|---|---|
| | | **Transfusion Medicine** |
| 86900 | | Blood typing ABO |
| 86901 | | Blood typing RH |
| 86850 | | Antibody Screen (IDC) |
| 86870 | | Antibody Identification |
| 86920 | | Crossmatch _____ units PRBC |
| 86880 | | Direct Coombs |
| 86850 | | Indirect Coombs Qualitative |
| | | Transfuse Rhogam |
| 86886 | | Antibody Titer |
| 86905 | | Antigen Type (patient) |
| | | **Single Tests** |
| 86038 | | Antinuclear Antibody (ANA) Screen |
| 83036 | | Hemoglobin A1C |
| 86703 | | HIV Screen |
| 86308 | | MONO Test |
| 86592 | | RPR Screen |
| 86762 | | Rubella Antibody IgG |
| 82950 | | 1 Hour GTT___ |
| 84165 | | Serum Protein Electrophoresis |
| 84155 | | Urine Protein Electrophoresis |

| CPT | ✓ | Single Tests |
|---|---|---|
| | | **Microbiology** |
| 87088 | | Urine Culture |
| 87045/ 87046 | | Feces (stool) Culture |
| source | | Routine Culture (other) **must** specify specimen source _____ |
| 87040 | | Blood Culture |
| 87050 | | AFB Culture specimen source _____ |
| 87102 | | Fungus Culture specimen source _____ |
| 87254 | | Virus Culture specimen source _____ |
| 87254 | | Herpes Culture specimen source _____ |
| | | Rapid Strep Antigen Screen |
| | | Rotavirus Antigen |
| 87420 | | RSV Antigen |
| 89055 | | Stool for WBC's |

| CPT | ✓ | Molecular Pathology |
|---|---|---|
| | | **Flow Cytometry Protocol Studies** |
| 88184 | | ☐ Leukemia/Lymphoma Study |
| 88185 | | • NOTE: If correlating morphology is not available, a White Cell Count with Differential will be performed and billed. |
| 86361 | | ☐ **CD4** Helper T-Cells |
| | | • NOTE: If correlating morphology is not available, a White Cell Count with Differential will be performed and billed. |
| | | **Molecular Protocol Studies** |
| 87536 | | ☐ HIV-1 RNA QN bDNA (V3.0) |
| 87491 | | ☐ Chlamydia Trachomatis by PCR |
| 87591 | | ☐ **Neisseria Gonorrhoeae by PCR** |
| | | **Molecular Protocols For Referral Lab** |
| | | ☐ FISH |
| | | ☐ Cytogenetics |
| | | ☐ Southern Blot |
| | | ☐ Polymerase Chain Reaction (PCR) |
| | | **Specimen** |
| | | ☐ Peripheral Blood |
| | | ☐ Bone Marrow Aspirate |
| | | ☐ Cerebral Spinal Fluid |
| | | ☐ Effusion, Source _____ |
| | | ☐ FNA, Site _____ |
| | | ☐ Fresh Tissue, Type & Site _____ |
| | | ☐ Paraffin Block, Site & Block # _____ |
| | | ☐ Slides, Site & Accession# _____ |

**Other test required. Write complete test name legibly. Other information related to test(s) requested.**

Only tests or Medicare Approved Panels that are medically necessary for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. Screening tests will not be reimbursed and should not be submitted for payment. The OIG states that a physician who orders medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the False Claims Act.

**Physician Signature (required)** Date/Time

**THIS FORM PART OF PERMANENT MEDICAL RECORD**

*0642*

ORIGINAL - LABORATORY YELLOW - PATIENT PINK - PHYSICIAN

# OutPatient Requisition

LA-104 (12/10 v.15)