REQUEST FOR SPECIMEN ANALYSIS

PLEASE PRINT OR TYPE LEGIBLY

ASPIRUS ST. LUKE'S

INFORMATION REQUESTED NECESSARY FOR CONSULTATION AND INSURANCE. IF INSURANCE INFORMATION IS NOT LISTED THE CLIENT WILL BE BILLED

SPECIAL BILLING REQUIREMENTS:	ABN SIGNED: [ ] YES [ ] NO	PATIENT NAME: LAST NAME FIRST NAME		CHART NO.
HOSPITAL/CLINIC: (PLEASE WRITE LOCATION)		DOCTOR:	SEX:	DATE OF BIRTH:
		GUARANTOR ADDRESS:		CODE:
		CITY: STATE: ZIP:		
[ ] MEDICARE	ID NUMBER:			HCO NO.
[ ] MEDICAID	POLICY NUMBER:			PCO NO.
[ ] INSURANCE	GROUP NUMBER:			
INSURANCE COMPANY ADDRESS: (OR ATTACH A COPY OF THE FRONT/BACK OF INSURANCE CARD)				

PHYSICIAN SIGNATURE REQUIRED:			DO NOT WRITE IN THIS AREA	
			PATIENT NO. __ __ __ __ __ __ __	PATIENT TYPE
ICD-10 CODE (REQUIRED)	SPECIMEN COLLECTION DATE AND TIME	COLLECTED BY	MR NO. __ __ __ __ __ __	FINANCIAL CLASS

[ ] STAT [ ] PHONE TO: _____ [ ] FAX TO: _____

ONLY TESTS MEDICALLY NECESSARY FOR DIAGNOSIS OR TREATMENT OF A PATIENT MAY BE ORDERED WHEN MEDICARE REIMBURSEMENT WILL BE SOUGHT

PATHOLOGY SPECIMEN

[ ] PERIPHERAL SMEAR TO PATHOLOGY
include diagnosis, related test results, EDTA tube, & stained smears

[ ] BONE MARROW TO PATHOLOGY
include diagnosis, related test results, EDTA tube, & unstained smears

[ ] TISSUE SPECIMENS
include ICD-10 code, clinical diagnosis, & Site or Origin

PLACE HPV STICKER HERE:

CLINICAL DIAGNOSIS AND HISTORY (REQUIRED FOR TISSUE & CYTOLOGY SPECIMENS):

SITE OF ORIGIN:

CYTOLOGY SPECIMEN

[ ] CERVICAL SMEAR (PAP)
[ ] VAGINAL SMEAR
[ ] ENDOCERVICAL
(CHECK ONE)
[ ] SCREENING [ ] DIAGNOSTIC

[ ] PREGNANT
[ ] POST PARTUM
[ ] HORMONE THERAPY
[ ] HYSTERECTOMY
LMP _____

PREVIOUS ABNORMAL PAP SMEAR
[ ] YES [ ] NO DX: _____

URINE	[ ] VOIDED SPECIMEN [ ] BLADDER CATHETER [ ] CYSTOSCOPY
SPUTUM	NO. _____ OF A SERIES (EARLY A.M.) [ ] POST BRONCHOSCOPY
SPINAL FLUID	VOLUME: _____
BODY FLUID	SITE: _____
WASHINGS	[ ] LEFT SITE: _____ [ ] RIGHT SITE: _____
BRUSHINGS	[ ] LEFT SITE: _____ [ ] RIGHT SITE: _____
ASPIRATION	[ ] LEFT SITE: _____ [ ] RIGHT SITE: _____ CYST FLUID [ ] YES [ ] NO
SMEAR FOR VIRAL DISEASE	SITE: _____
BREAST SECRETION	[ ] LEFT [ ] RIGHT
OTHER SMEARS	SITE: _____

MEDICARE/MEDICAID PATIENTS

I certify that the information given by me in applying for payment under Title XVIII or XIX of the (CLIA # 24D0404051) Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished me by St. Luke's Hospital, including physician services, and assign such benefits to St. Luke's Hospital.

I authorize St. Luke's Hospital to release to Medicare/Medicaid and its agents any information needed to determine these benefits for related services. I understand I am responsible for the costs of non-covered services and for the costs of non-covered services and for deductible, co-insurance, and co-payment charge allowed under federal regulations.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize St. Luke's Hospital to release information to my insurance company for payment of my hospital bill. This authorization shall include release of information to the Social Security Administration needed for payment under Title VXIII or XIX of the Social Security Act. I understand I have a right to revoke this consent through written notification to St. Luke's Hospital.

FINANCIAL AGREEMENT

I agree to pay the hospital for all services rendered to me at the regular rates, including service which, for any reason, are not paid for by insurance, governmental programs, or other third party sources. I authorize payment to St. Luke's Hospital of insurance benefits otherwise payable to me from my insurance company(ies) or any other insurance benefits to which I am entitled to reimbursement for medical expenses or other benefits.

PATIENT SIGNATURE REQUIRED FOR BILLING (EXCEPT: MEDICARE/MEDICAID/BLUE CROSS)

DATE: _____ SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ WITNESS

(RELATIONSHIP)

I ACCEPT THE FINANCIAL RESPONSIBILITY AS OUTLINED ABOVE

_____

SIGNATURE OF GUARANTOR