Bay Area Hospital

LB0060

Date testing is scheduled for: _____

Orders will be pulled 3 months after scheduled date.

Laboratory
1775 Thompson Road
Coos Bay, OR 97420 Phone 541-269-8071 **FAX** 541-269-8373

Patient's Last Name First MI	Sex	DOB	**Reporting Information**
			☐ **Stat** ☐ **Fax Report** _____ **Copy to:** _____

☐ **Medicare** ☐ **Medicaid** ☐ **OTHER**

Lab Use Only ☐ Signed ABN obtained
Account #

Location of patient Initials **Phoned-in** ☐

☐ Lab ☐ Reference Spec.

REMEMBER TO READ BACK

Referring Provider / Client	**Collection Information**
Provider name (Printed) _____ _____ (Address & Phone, if not local) **Date** _____ **Time** _____ **Provider Signature** _____	Date Collected: _____ Time Collected: _____ Fasting: _____ HRS

ICD-10 Code 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

It is essential physicians provide the diagnosis code for proper billing. Physicians should only order tests that are medically necessary for the diagnosis or treatment of their patients. Medicare generally does not cover routine screening tests. The physician also understands he or she is required to submit ICD-10 diagnosis supported in the patient's record as documentation of the medical necessity or explain and have the patient sign an ABN

*****Tests listed in RED may require Advance Beneficiary Notice (ABN) signature*****

Additional tests:

PANELS (see reverse for components)	☐ ANA	☐ HIV 1/2 AG & AB Screen	☐ Urine, HCG
	☐ ANA Reflex profile	☐ HbsAG	☐ Uric Acid
☐ Electrolytes Panel	☐ Bilirubin, Direct	☐ HbsAB	☐ Vancomycin
☐ Basic Metabolic Panel	☐ Bilirubin, Neonatal <15 days	☐ HCV, reflex to HCV RNA	☐ Trough _____ (last dose)
☐ Iron Panel	☐ Bilirubin, Total	☐ Iron	☐ Peak _____ (last dose
☐ Lipid Panel	☐ NT-pro BNP	☐ LDH	☐ Vitamin B12
☐ Fasting ☐ Non fasting	☐ Calcium	☐ Lactate	☐ Vitamin D, 25-Hydroxy
☐ Comprehensive Metabolic Panel	☐ CA 15-3	☐ Magnesium	
☐ Liver Panel	☐ CA 19-9	☐ Microalbumin/Creatinine Ratio Random Urine	
☐ Renal Panel	☐ CA 125		
☐ Hepatitis B&C, chronic w/reflex	☐ CEA	☐ Potassium	**MICROBIOLOGY**
☐ Hep ABC Acute/Comp w/reflex	☐ C Reactive Protein (CRP)	☐ Phosphorous	☐ Aerobic Culture ☐ Anaerobe
	☐ Cholesterol	☐ Protein, Total	☐ Gram Stain
	☐ Cortisol	☐ Rheumatoid Screen	_____
HEMATOLOGY/COAGULATION	☐ CPK	☐ reflex to RA factor if positive screen	Source: (required)
☐ CBC (Hemogram)	☐ Creatinine	☐ Rubella, IgG	☐ MRSA / MSSA screen by PCR, nasal
☐ CBC with Differential (manual differential reflex if meets criteria)	☐ Digoxin Last Dose _____	☐ Rubeola, IgG	☐ Culture, Blood X _____
☐ D-Dimer	☐ Dilantin Last Dose _____	☐ T4, Free	☐ Culture, Stool
☐ INR / Protime		☐ T3, Total	
☐ PTT	☐ Estradiol	☐ Testosterone, Total	☐ Culture, Urine
☐ Sed Rate	☐ Fecal Lactoferrin (Stool for WBC)	☐ Testosterone, Free & Total	☐ clean catch ☐ I/O ☐ indwelling
	☐ Fecal Occult Blood diagnostic	☐ TSH	☐ C.diff AG/Toxin
	☐ Fecal Occult Blood screening	☐ Triglycerides	☐ Cryptosporidium / Giardia
ALPHABETICAL TEST LISTING	☐ Ferritin	☐ Troponin I	☐ Rapid Strep Antigen
☐ AFP Alpha-fetoprotein	☐ Folate	☐ PSA, Diagnostic	Reflex to culture if negative
☐ Alkaline Phosphatase	☐ GGT	☐ PSA, Screening	☐ Flu A&B
☐ Amylase	☐ Glucose	☐ UA, Dipstick w/o microscopic	☐ COVID, Rapid
	☐ Glycohemoglobin (A1C) with est. average glucose	☐ clean catch ☐ I/O ☐ indwelling	
	☐ HCG, Qualitative	☐ UA, with microscopic	
	☐ HCG, Quant	☐ clean catch ☐ I/O ☐ indwelling	☐ GC/Chlamydia PCR
		☐ UA, with microscopic & cult if indicated	Source: _____
		☐ clean catch ☐ I/O ☐ indwelling	

Basic Metabolic Panel

BUN
Calcium
Chloride
CO_2
Creatinine (inc GFR)
Glucose
Potassium
Sodium

Comprehensive Metabolic Panel

Albumin
Alk Phos
ALT
AST
Bilirubin, Total
BUN
Calcium
Chloride
CO_2
Creatinine
Glucose
Potassium
Sodium
Total Protein

Electrolyte Panel

Chloride
CO_2
Potassium
Sodium

Liver Panel

Albumin
Alk Phos
ALT
AST
Bilirubin, Direct
Bilirubin, Total
Total Protein

Renal Panel

Albumin
BUN
Calcium
Chloride
CO_2
Creatinine
Glucose
Phosphorous
Potassium
Sodium

Lipid Panel

Cholesterol
Cholesterol/HDL
HDL
LDL
LDL / HDL
Triglycerides
VLDL

Iron Panel

Iron
Total Iron Binding Capacity
Transferrin Sat %
UIBC

Hepatitis ABC Acute/Comprehensive with Reflex

Hepatitis A Antibody, IgM
Hepatitis B Core Antibody, IgM
Hepatitis B Surface Antigen
Hepatitis C Virus Antibody

Other panels are available; visit
Mayo Clinic Laboratories for full listing.
https://www.mayocliniclabs.com

Hepatitis B & C Chronic with Reflex

Hepatitis B Core Antibody
Hepatitis B Surface Antigen
Hepatitis B Core Antibody, TOTAL
Hepatitis C Virus Antibody

Other panels are available; visit
Mayo Clinic Laboratories for full listing.
https://www.mayocliniclabs.com

Definition for fasting:

- **Lipid panels** require fasting with no food or drink other than water, 12 hours prior to the test. We require fasting unless your Doctor has clearly indicated Non-Fasting.
- **Other Fasting tests such as glucose** require you to avoid any food or drink other than water, eight (8) hours prior to the test. We require fasting unless your Doctor has clearly indicated Non-Fasting.

Reflex Testing Criteria:

- **UA with microscopic: culture if indicated.**
  A culture is added if WBC **greater than** 5-10/HPF and /or **greater than/equal to** 1+ leukocyte esterase.
  Children **greater than/equal to** 3 years old to **less than** 13 years old, culture is added if WBC **greater than** 5/HPF

Any testing not performed at Bay Area Hospital will be forwarded to our reference lab Mayo Clinic Laboratories.
You may access their web site at https://www.mayocliniclabs.com for a listing of tests.

Patient Name _____ Identification Number (Acct #) _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare does **not** pay for 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 test(s) below.

Laboratory Test(s):			Reason Medicare may not pay:	Estimated cost:
☐ A1C	☐ Digoxin	☐ Prothombin time (PT)		
☐ AFP	☐ Flow Cytometry	☐ Partial Thromboplastin Time (PTT)		
☐ BNP – BNaturetic Peptide	☐ GGT	☐ Prostatic Specific Antigen (Free and Total)		
☐ CBC, Hemogram, Platelets	☐ Glucose	☐ Thyroid tests (T3, T4, TSH, Free T4, T3U)		
☐ CA-125	☐ HCG Quantitative	☐ Vitamin D		
☐ CA 15-3 or CA 27-29	☐ Hepatitis Panel, Acute	☐ Urine Culture		
☐ CA 19-9	☐ HIV Diagnostic or Prognosis			
☐ CEA	☐ Iron studies (Ferritin, Iron, IBC, Transferrin)			
☐ Collagen Cross Links	☐ Lipid tests (Chol, Trig, HDL, LDL)			
☐ Cytogenetics Testing	☐ Magnesium	☐ Research or investigational tests not paid by Medicare		

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 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.

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

☐ **OPTION 1.** I want the _____ 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 does not 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 _____ 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 do not want the _____ 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:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Bay Area Hospital - Laboratory 541-269-8071
1775 Thompson Rd., Coos Bay, OR, 97420
ABN of Non-Coverage
7010-048MREV0920

^ L B 0 0 1 0 ^

Original to Health Information Management (HIM)

BAY AREA HOSPITAL

NON-COVERED SERVICES CONSENT

Patient Name _____ DOB _____

Account # _____ Medical Record # _____

I understand that the services listed below may not be considered eligible for benefits (for example, services may be determined to not be medically necessary, non-covered or investigational) by my health plan.

I understand my health insurance coverage has certain restrictions and limitations such as authorization requirements, and non-covered services and / or supplies.

Service requested:
- ☐ **Vitamin D testing**
- ☐ **Allergen testing**
- ☐ **Other**_____

Approximate cost: $ _____

Check only one box.

☐ **OPTION 1**. I choose to have the service listed above and have my insurance billed, knowing the cost may be declined if not medically necessary and I will be responsible for payment.

☐ **OPTION 2.** I choose to have the service and pay for it today.

☐ **OPTION 3.** I decline the service.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date Time

LB0010