

PHYSICIAN INFORMATION	PATIENT INFORMATION
Requesting Physician Signature _____ Referring Physician _____	Last Name _____ First Name _____ MI _____ <hr/> Date of Birth _____ Street Address _____ <hr/> City _____ State _____ Zip _____ <hr/> Gender <input type="checkbox"/> F <input type="checkbox"/> M _____ () - _____ Chart Number _____ Patient Telephone No. _____

BILLING INFORMATION REQUIRED (Attach copies of Insurance card: Primary and Secondary)

If minor, Guardian Name _____ Insurance Co. _____

Subscriber # _____ Group # _____ Relation to Patient: self spouse guardian

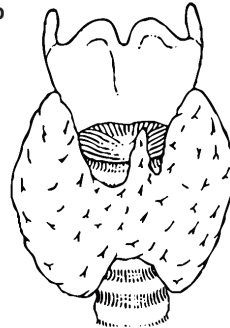
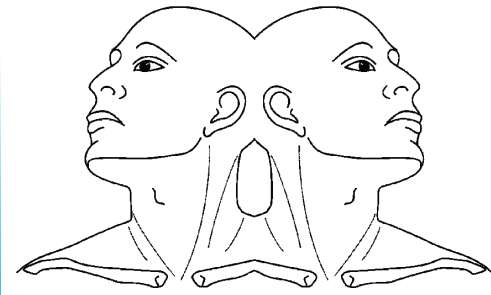
Insured's Name _____ Insured Employer _____

Bill Insurance
 Uninsured
 Indigent Patient
 Bill Doctor
 Medicare Waiver on Back(ABN)

SPECIMEN INFORMATION

Collection Date: _____ Time: _____ Specimen ID #(s): _____ **ICD-9 Code REQUIRED:** _____

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Thyroid Map 	Please indicate site and size: Specimen A: _____ Specimen B: _____ Specimen C: _____ Specimen D: _____	
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CLINICAL HISTORY / DIAGNOSIS

Thyroid

Ultrasound Findings: Multinodular Solitary Nodule Solid Cystic

Ultrasound/Clinical Level of Concern: Low High Intermediate

Thyroid Serum Antibody results if available: _____

Other Relevant History: _____

Thyroid Scan Results: Cold Warm Hot

History of Radiation Exposure: Yes No

Family History of Thyroid Cancer: Yes No

Lymph Node

Solitary Adenopathy Metastatic Carcinoma Panel

Multiple Adenopathy Lymphoma Panel (additional specimen in RPMI for Flow Cytometry)

Other Panel: _____

Reflex Parathyroid Hormone

Reflex Thyroglobulin (reflex FNA Aspirate submitted in saline)

Reflex to Flow Cytometry (submit in RPMI only)

Salivary Gland

Size: _____ Peripheral Nerve Symptoms: _____ Duration of Lesion: _____

Other Site

Specify: _____ Size: _____ Duration: _____

Comments or Clinical Impression: _____

For LAB PURPOSES ONLY





NOTES: _____

ACCESSION # _____

DATE/TIME Rec'd. _____

Positive Patient Identification: No.

- Specimen Label Instructions:**
1. Remove the necessary labels and place one (1) label on each specimen container (not on the lid).
 2. Please be sure to write in any necessary information on the labels.

			
_____	_____	_____	_____



A. Notifier:

6116 E Warren Ave ● Denver, CO 80222 ● Phone: (303) 512-0888 ● Fax: (303) 512-2246

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the **D. 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 **D. laboratory test(s)** below.

D. Laboratory Test(s)	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. 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.

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

- OPTION 1.** I want the **D. 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 **D. 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 **D. 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.**

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.

I. Signature:	J. Date:
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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.