



# COMPREHENSIVE NEPHROPATHOLOGY REQUISITION

PHYSICIAN HOT LINE 303.839.6851 8:30AM-5:00PM or CUSTOMER SERVICE 1.866.UNIPATH(864.7284)

## PHYSICIAN INFORMATION

Requesting Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender  F  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 Hospital System  Bill Insurance  Uninsured  Indigent Patient  Bill Doctor  Medicare Waiver on Back(ABN)

## CLINICAL HISTORY AND DATA

Biopsy Type:  Native  Transplant

Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_ Specimen ID #(s): \_\_\_\_\_

ICD-9 Code REQUIRED: \_\_\_\_\_

Relevant History: \_\_\_\_\_

## APPROPRIATE CLINICAL SYNDROME

	Time Frame		Time Frame
<input type="checkbox"/> Nephrotic Syndrome.....	_____	<input type="checkbox"/> Isolated Hematuria ( Micro / Macro ).....	_____
<input type="checkbox"/> Acute Nephritic Syndrome.....	_____	<input type="checkbox"/> Isolated Proteinuria.....	_____
<input type="checkbox"/> Acute Renal Failure.....	_____	<input type="checkbox"/> Chronic Renal Failure.....	_____
<input type="checkbox"/> Rapidly Progressive Glomerulonephritis.....	_____	<input type="checkbox"/> Other _____	_____

## LABS AND SEROLOGIES

Labs:	Serologies:
Serum Creatine _____ mg/dl	ANA _____ cANCA _____ SPEP/UPEP _____ C3 _____
Creatine Clearance _____ ml/min	RF _____ pANCA _____ Cryo _____ C4 _____
24 hour Urine Protein _____	ant-ds DNA _____ Hep B _____ HIV _____ CH50 _____
Antirejection Therapy Prior to Biopsy _____	antiGBM _____ Hep C _____ ASO _____

Additional Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For LAB PURPOSES ONLY**

ACCESSION # \_\_\_\_\_

DATE/TIME Rec'd. \_\_\_\_\_



**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.

<b>I. Signature:</b>	<b>J. Date:</b>
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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.