

LABCORP TEST REQUEST FORM REQUIREMENTS

Check One

03 Client Bill

04 Patient Bill

05 Medicare, Traditional

ST* Medicaid, Traditional

XI Private Insurance/ Managed Care

ST* = State Abbreviation

Patient's Legal Name (Last, First, MI)		Sex	Date of Birth MO DAY YR			Collection Time AM <input type="checkbox"/> Yes PM <input type="checkbox"/> No	Fasting <input type="checkbox"/> Yes <input type="checkbox"/> No	Collection Date MO DAY YR			Urine hrs/vol hrs ____ vol ____
NPI		Physician's ID #		Patient's ID #			Hospital Patient Status: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Non-Patient				
Physician's Name (Last, First)		Physician/Authorized Signature X _____									
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service Highest Specificity REQUIRED											
PRIMARY BILLING PARTY						SECONDARY BILLING PARTY					
Insurance Carrier *						Insurance Carrier *					
ID #						ID #					
Group #						Group #					
Insurance Address						Insurance Address					
Name of Insured Person						Name of Insured Person					
Relationship to Patient						Relationship to Patient					
Employer Name						Employer Name					
*If Medicaid State		Physician's Provider #				Workers Comp <input type="checkbox"/> Yes <input type="checkbox"/> No					

PATIENT

Patient's Address _____ Phone _____

City _____ State _____ ZIP _____

Name of Policy Holder (if different from patient) _____

Address of Policy Holder _____ APT # _____

City _____ State _____ ZIP _____

I hereby authorize the release of medical information related to the service described herein and authorize payment directly to LabCorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X _____ Date _____

MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Refer to Determining Necessity of ABN Completion on reverse.

Client Bill

- Billing Option
- Date Collected
- Time Collected
- Patient Legal Name (Last, First, MI)
- Patient Gender
- Patient Date of Birth
- Physician Last & First Name

Optional

- Patient ID N°
- Physician ID N°

Client

+ Patient

+ + + + Medicare, Traditional

+ + + Medicaid, Traditional

+ + + Private Insurance/
Managed Care

Fields not highlighted may be necessary for certain types of testing or to meet individual payor-specific requirements.

Patient Bill

- Billing Option
- Date Collected
- Time Collected
- Patient Legal Name (Last, First, MI)
- Patient Gender
- Patient Date of Birth
- Patient Address (city, state, & ZIP code)
- Patient Telephone N°, with area code
- Physician Last & First Name

Medicare, Traditional

- Billing Option
- Date Collected
- Time Collected
- Patient Legal Name (Last, First, MI)
- Patient Gender
- Patient Date of Birth
- Patient Address (city, state, & ZIP code)
- Patient Telephone N°, with area code
- Physician Last & First Name
- NPI
- Authorized Signature for Medical Release
- ICD-CM Diagnosis Codes (in format in effect at date of service and at highest specificity)
- ABN Signed & Dated when applicable (Refer to instructions on back of test request form)
- Primary Billing Party - complete Traditional Medicare information
- Secondary Billing Party - complete insurance information as applicable to patient

Medicaid, Traditional

- Billing Option
- Date Collected
- Time Collected
- Patient Legal Name (Last, First, MI)
- Patient Gender
- Patient Date of Birth
- Patient Address (city, state, & ZIP code)
- Patient Telephone N°, with area code
- Physician Last & First Name
- Physician Signature
- NPI
- Authorized Signature for Medical Release
- ICD-CM Diagnosis Codes (in format in effect at date of service and at highest specificity)
- Primary Billing Party - complete Traditional Medicaid information
- List State Abbreviation
- Physician's State Assigned Provider N°

Private Insurance/ Managed Care

- Billing Option
- Date Collected
- Time Collected
- Patient Legal Name (Last, First, MI)
- Patient Gender
- Patient Date of Birth
- Patient Address (city, state, & ZIP code)
- Patient Telephone N°, with area code
- Physician Last & First Name
- NPI
- Authorized Signature for Medical Release
- ICD-CM Diagnosis Codes (in format in effect at date of service and at highest specificity)
- Responsible Party, if different from patient
- Primary Billing Party - complete insurance information, specify if MC or MD HMO/PPO
- Secondary Billing Party - complete insurance information as applicable to patient



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Optional

- Hospital Status