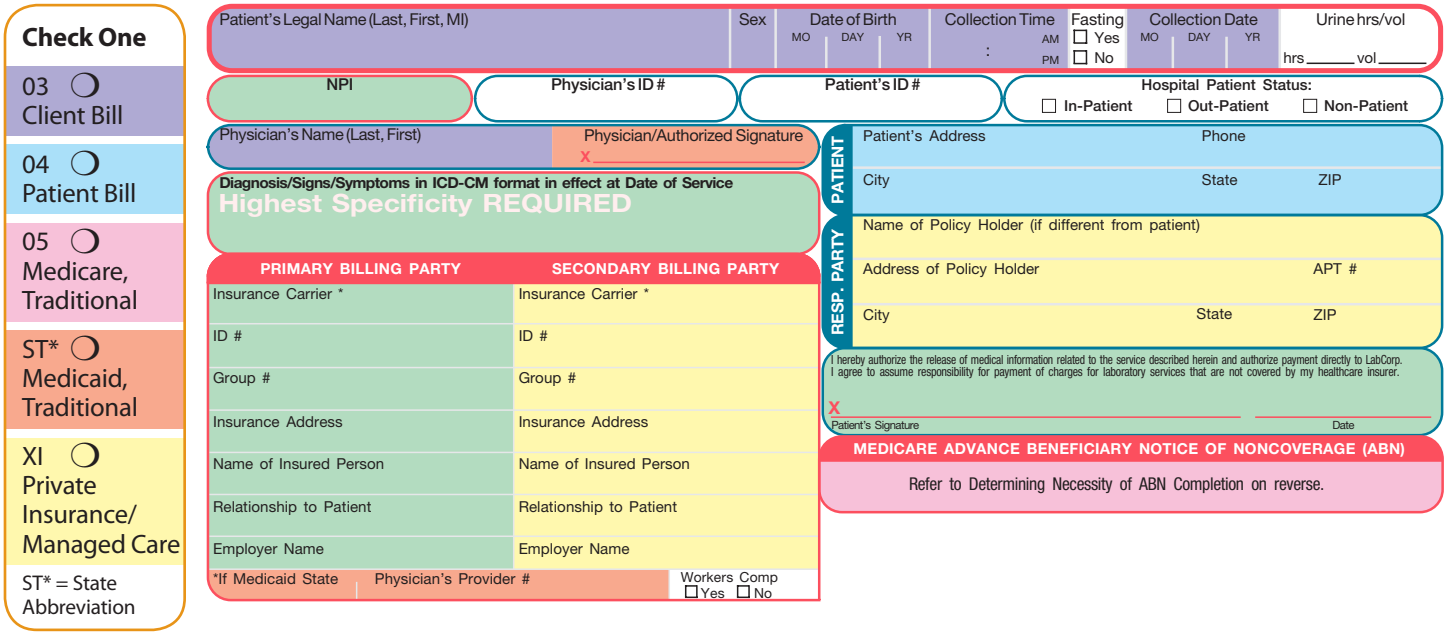
LABCORP TEST REQUEST FORM REQUIREMENTS



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°

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

Client

Client + Patient

Client + Patient + Medicare, Traditional

Client + Patient + Medicaid, Traditional

Client + Patient + Private Insurance/ Managed Care

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

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

Optional

- Hospital Status

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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