TO BILL YOUR OFFICE (Required Information)

- (1) Indicate Ordering Provider
- (2) Collection date/time, phlebotomist initials
- (3) Indicate valid ICD9 code(s)
- (4) Mark the Clinic option in the "SEND BILL TO" Box
- (5) Patient Name*
- (6) Patient Social Security Number*
- (7) Sex
- (8) Date of Birth

*When submitting coded/anonymous specimens, the patient name and social security number may be omitted.

	+
Legacy Laboratory Services 503-413-1234 877-270-5566 877-270-5566 878-71234 8887-888-503-413-5048 65 98908MN OLUCUEUE	Last Last Last First First First
DATE: ② TIME: BY:	Last Last Last First First
CLINIC SEND BILL TO (REQUIRED) SEND BI	DUPLICATE REPORT TO: (PROVIDER'S FULL NAME & ADDRESS)
MAILING ADDRESS (REQUIRED FOR INSURANCE & PATIENT BILLING) CITY/STATE ZIP PATIENT PHONE NO.	FAX RESULTS To comply with HBPAI, results will only be faxed to the designated number on fine at legacy Laboratory). STAT OF STAT, PLACE STICKER ON OUTSIDE OF SPECIMEN BAG) PHONE RESULTS
RISURANCE CO. NAME & ADDRESS (ORATTACH COPY OF CARID): INSURANCE ID NO. GROUP NO.	GYNECOLOGIC CYTOLOGY Conventional Smear Liquid-based Thin Prep Liquid-based SurePath Reason: Diagnostic Routine Cervical Vaginal LMP or #Yrs PMP: HPV Test Options:
MEDICATID / OMAP LD. NO. MEDICARE NO. & LETTER ABN SIGNED PIEASE ATTACH) SS L U B R GY GN S P ROYAL SST TUBE LAVENDER URINE BLUE RED GRAY GREEN SERUM PLASMA BLUE	Hx Abn Pap (date & dx:) HxP High, Risk & Liquid-based Pap (ASCUS Dx only) Hysterectomy (cervix intact) HRT Pregnant wks BCP IUD Post partum wks Abn bleeding Other Info: WRY HPV High, Risk & Liquid-based Pap (ARV) DX HPV
C V F FOOZEN LCX MISC COLUTINE YELLOW FROZEN LCX MISC COPED INS CARD PROMENT RECD LEGACY LABORATORY USE ONLY RECD BY ROE AUDIT EDIT LAST DOSE: DATETIME	□ SURGICAL PATHOLOGY □ NON GYN CYTOLOGY □ FINE NEEDLE ASPIRATE SPECIMEN SOURCE: 1

DID YOU REMEMBER...

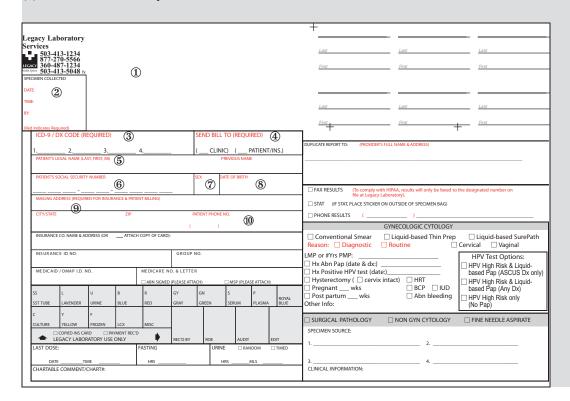
To mark Clinic in the "BILL TO" box?

To request or mark tests?

TO BILL YOUR PATIENT SELF PAY (Required Information)

- (1) Indicate Ordering Provider
- (2) Collection date/time, phlebotomist initials
- (3) Indicate valid ICD9 code(s)
- (4) Mark the "Patient/ins" option in the "SEND BILL TO" Box
- (5) Patient Name
- (6) Patient Social Security Number

- (7) Sex
- (8) Date of Birth
- (9) Patient Address (include Zip)
- (10) Patient Phone (include area code)



DID YOU REMEMBER...

To mark or indicate ordering provider?

To mark Patient (self pay) in the "BILL TO" box?

To include diagnosis code(s)?

TO BILL MEDICARE / MEDICAID (Required Information)

- (1) Indicate Ordering Provider
- (2) Collection date/time, phlebotomist initials
- (3) Indicate valid ICD9 code(s) reflecting medical necessity
- (4) Mark the Patient/Ins option in the "SEND BILL TO" box
- (5) Patient Name as it Appears on Medicare / Medicaid Card
- (6) Patient Social Security Number

- (7) Sex
- (8) Date of Birth
- (9) Patient Address (include Zip)
- (10) Patient Phone (include area code)
- (11) Patient Medicaid recipient ID#
- (12) Patient Medicare # (including suffix)

Legacy Laboratory Services \$03-413-1234 \$77-270-5566 IECT 300-487-1234 MANAMA SIGNATURE DATE 2 TIME	Last			
BY. (Red bedicates Required)	First First First			
ICD-9 / DX CODE (REQUIRED) 1. 2. 3. 4. (CLINIC) (PATIENT/INS.) PATIENTS LEGAL NAME (LAST, FRIST, MI) PREVIOUS NAME	DUPLICATE REPORT TO: PROVIDERS FULL NAME & ADDRESS)			
MALING ADDRESS BEQUIRED FOR INSURANCE & PATIENT BILLING) CITY/STATE 2IP PATIENT PHONE NO. (II)	FAX RESULTS (To comply with HIPAA, results will only be faxed to the designated number on file at Legacy Laboratory). STAT (IF STAT, PLACE STIKER ON OUTSIDE OF SPECIMEN BAG) PHONE RESULTS			
INSURANCE CO, NAME & ADDRESS (ORATTAGH COPY OF CARID):	GYNECOLOGIC CYTOLOGY Conventional Smear Liquid-based Thin Prep Liquid-based SurePath Reason: Diagnostic Routine Cervical Vaginal			
INSURANCE ID NO. MEDICAID / OMAP LD. NO. MEDICAID / OMAP LD. NO. MEDICAIR NO. & LETTER □ AN SIGNED PLASE ATTACH SS L U B R GN GN SP PLASE ATTACH SST TURE LAVENDER URINE BLUE BED GRAY GREN SERUM PLASMA BLUE	LMP or #Yrs PMP: Hx Abn Pap (date & dx:) Hx Positive HPV test (date:) Hysterectomy (cervix intact) HRT Pregnant wks BCP IUD Post partum wks Abn bleeding Other Info: (No Pap)			
CULTURE YELOW FOOZEN LCX MISC COPED INS CARD PRYMENT RECD RECD BY ROE AUDIT EDIT LEGACY LABORATORY USE ONLY FASTING URINE RANDOM TIMED DATETIME HRS HRS HRS HRS CHARTABLE COMMENT/CHART#:	SURGICAL PATHOLOGY NON GYN CYTOLOGY FINE NEEDLE ASPIRATE SPECIMEN SOURCE: 1. 2. 4. CLINICAL INFORMATION:			

DID YOU REMEMBER...

To mark or indicate ordering provider?

To include diagnosis codes?

To request or mark tests?

To complete MSP and ABN if necessary?

For questions on Medicare Compliance, please call 503-413-2291

TO BILL INSURANCE (Required Information)

- (1) Indicate Ordering Provider
- (2) Collection date/time, phlebotomist initials
- (3) Indicate valid ICD9 code(s)
- (4) Mark the Patient/Ins option in the "SEND BILL TO" box
- (5) Patient Name as it Appears on Insurance Card
- (6) Patient Social Security Number
- (7) Sex

- (8) Date of Birth
- (9) Patient Address (include Zip)
- (10) Patient Phone (include area code)
- (11) Insurance Co. Name, Address, Zip Attach copy of insurance card
- (12) Insurance Member ID#
- (13) Insurance Group #

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503-413-1234 877-270-5566								Last Last Last	
EGACY 360-487-1234								First First First	
SPECIMEN COLLECTED 1									
DATE:			`						
C	2)								
TIME:	_								Last Last
BY:									
Red Indicates Re									First First First
ICD-9 / DX CODE (REQUIRED) (3) SEND BILL TO (REQUIRED)									
1. 2. 3. 4. (CLINIC) (PATIENT/INS.)									DUPLICATE REPORT TO: (PROVIDER'S FULL NAME & ADDRESS)
PATIENT'S LEGAL NAME (LAST EIRST MI) _ PREVIOUS NAME									
			<u> </u>						
PATIENT'S S	OCIAL SECURITY		6)		SEX	(7) DATE O	BIRTH 8		
			<u> </u>		_	ω	0		FAX RESULTS (To comply with HIPAA, results will only be faxed to the designated number on file at Legacy Laboratory).
MAILING A	DDRESS (REQUIR	ED FOR INSUR	ANCE & PAT	IENT BILLING)					STAT (IF STAT, PLACE STICKER ON OUTSIDE OF SPECIMEN BAG)
CITY/STATE	(9)		ZIP		PATI	ENT PHONE NO.			□ PHONE RESULTS ()
	90							GYNECOLOGIC CYTOLOGY	
INSURANCE CO. NAME & ADDRESS (OR ATTACH COPY OF CARD):								☐ Conventional Smear ☐ Liquid-based Thin Prep ☐ Liquid-based SurePath	
INSURANCE CO. NAME & ADDRESS (OR AT IACH COPY OF CARD):								Reason: Diagnostic Routine Cervical Vaginal	
INS UR AN	CE ID NO.			-	GROUP NO				LMP or #Yrs PMP: HPV Test Options:
		(12)			13			☐ Hx Abn Pap (date & dx:) ☐ HPV High Risk & Liquid-
ME DIC AIE	O / OMAP I.D. N	10.		MEDICARE N	O. & LETTER				☐ Hx Positive HPV test (date:) based Pap (ASCUS Dx only)
	1	1		☐ ABN SIGNED	(PLEASE ATTACH) _ M	SP (PLEASE ATTAC	EH)	☐ Hysterectomy (☐ cervix intact) ☐ HRT ☐ HPV High Risk & Liquid- ☐ Pregnant wks ☐ BCP ☐ IUD ☐ based Pap (Any Dx)
SS	L	U	В	R	GY C	in s	P	ROYAL	Post partum wks Abn bleeding HPV High Risk only
SST TUBE	LAVENDER	URINE	BLUE	RED	GRAY C	SREEN SEE	UM PLASN	IA BLUE	Other Info: (No Pap)
С	Υ	F							☐ SURGICAL PATHOLOGY ☐ NON GYN CYTOLOGY ☐ FINE NEEDLE ASPIRATE
CULTURE	YELLOW	FROZEN	LCX	MISC					SPECIMEN SOURCE:
	□ COPIED INS CARD □ PAYMENT REC'D LEGACY LABORATORY USE ONLY REC'D BY ROE AUDIT EDIT								
	LAST DOSE: FASTING URINE RANDOM TIMED						1 2		
DATETIME HRS HRSMLS						HRS	3. 4.		
	CHARTABLE COMMENT/CHART#:								CLINICAL INFORMATION:

DID YOU REMEMBER...

To mark or indicate ordering provider?

To include diagnosis code(s)?

To request or mark tests?

To attach copy of insurance card?