

TO BILL YOUR OFFICE (Required Information)

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

DID YOU REMEMBER...

To request or mark tests?

TO BILL YOUR PATIENT SELF PAY (Required Information)

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

DID YOU REMEMBER...

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 503-413-1234 877-270-5566 360-487-1234 503-413-5048		+		
SPECIMEN COLLECTED DATE: ② TIME: BY:		Last _____ Last _____ Last _____ First _____ First _____ First _____ Last _____ Last _____ Last _____ First + _____ First + _____ First + _____		
(Red Indicates Required) ICD-9 / DX CODE (REQUIRED) ③ 1. _____ 2. _____ 3. _____ 4. _____ PATIENT'S LEGAL NAME (LAST, FIRST, MI) ⑤ PATIENT'S SOCIAL SECURITY NUMBER ⑥ SEX ⑦ DATE OF BIRTH ⑧ MAILING ADDRESS (REQUIRED FOR INSURANCE & PATIENT BILLING) CITY/STATE ⑨ ZIP PATIENT PHONE NO. ⑩ INSURANCE CO. NAME & ADDRESS (OR ATTACH COPY OF CARD) INSURANCE ID NO. ⑪ GROUP NO. ⑫ MEDICAID / OMAP I.D. NO. MEDICARE NO. & LETTER SS L U B R GY GN S P ROYAL SST TUBE LAVENDER URINE BLUE RED GRAY GREEN SERUM PLASMA BLUE C Y F LCX MISC CULTURE YELLOW FROZEN LAST DOSE: DATE _____ TIME _____ FASTING _____ URINE _____ RANDOM _____ TIMED _____ CHARTABLE COMMENT/CHART#:		SEND BILL TO (REQUIRED) ④ (CLINIC) (PATIENT/INS.) PREVIOUS NAME DUPLICATE REPORT TO: (PROVIDER'S FULL NAME & ADDRESS) FAX RESULTS (To comply with HIPAA, results will only be faxed to the designated number on file at Legacy Laboratory.) STAT (IF STAT, PLACE STICKER ON OUTSIDE OF SPECIMEN BAG) PHONE RESULTS () GYNECOLOGIC CYTOLOGY Conventional Smear Liquid-based Thin Prep Liquid-based SurePath Reason: Diagnostic Routine Cervical Vaginal 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: HPV Test Options: HPV High Risk & Liquid-based Pap (ASCUS Dx only) HPV High Risk & Liquid-based Pap (Any Dx) HPV High Risk only (No Pap) SURGICAL PATHOLOGY NON GYN CYTOLOGY FINE NEEDLE ASPIRATE SPECIMEN SOURCE: 1. _____ 2. _____ 3. _____ 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 #

Legacy Laboratory Services 503-413-1234 877-270-5566 360-487-1234 503-413-5048		+		
SPECIMEN COLLECTED DATE: ② TIME: BY:		Last _____ Last _____ Last _____ First _____ First _____ First _____ Last _____ Last _____ Last _____ First + _____ First + _____ First + _____		
(Red Indicates Required) ICD-9 / DX CODE (REQUIRED) ③ 1. _____ 2. _____ 3. _____ 4. _____ PATIENT'S LEGAL NAME (LAST, FIRST, MI) ⑤ PATIENT'S SOCIAL SECURITY NUMBER ⑥ SEX ⑦ DATE OF BIRTH ⑧ MAILING ADDRESS (REQUIRED FOR INSURANCE & PATIENT BILLING) CITY/STATE ⑨ ZIP PATIENT PHONE NO. ⑩ INSURANCE CO. NAME & ADDRESS (OR ATTACH COPY OF CARD) INSURANCE ID NO. ⑪ GROUP NO. ⑫ MEDICAID / OMAP I.D. NO. MEDICARE NO. & LETTER SS L U B R GY GN S P ROYAL SST TUBE LAVENDER URINE BLUE RED GRAY GREEN SERUM PLASMA BLUE C Y F LCX MISC CULTURE YELLOW FROZEN LAST DOSE: DATE _____ TIME _____ FASTING _____ URINE _____ RANDOM _____ TIMED _____ CHARTABLE COMMENT/CHART#:		SEND BILL TO (REQUIRED) ④ (CLINIC) (PATIENT/INS.) PREVIOUS NAME DUPLICATE REPORT TO: (PROVIDER'S FULL NAME & ADDRESS) FAX RESULTS (To comply with HIPAA, results will only be faxed to the designated number on file at Legacy Laboratory.) STAT (IF STAT, PLACE STICKER ON OUTSIDE OF SPECIMEN BAG) PHONE RESULTS () GYNECOLOGIC CYTOLOGY Conventional Smear Liquid-based Thin Prep Liquid-based SurePath Reason: Diagnostic Routine Cervical Vaginal 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: HPV Test Options: HPV High Risk & Liquid-based Pap (ASCUS Dx only) HPV High Risk & Liquid-based Pap (Any Dx) HPV High Risk only (No Pap) SURGICAL PATHOLOGY NON GYN CYTOLOGY FINE NEEDLE ASPIRATE SPECIMEN SOURCE: 1. _____ 2. _____ 3. _____ 4. _____ 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?