

For Lab Use Only	Facility Name		Ordering Physician Name Last First	
	Address		Physician NPI No.	
	City, State, Zip		Physician Phone No. ()	
	Facility Phone Number ()		Report Fax Number ()	
Patient Name (Last) (First)			Insurance Info: Attach a copy of front & back of Insurance card or face sheet <input type="checkbox"/> Private Ins/PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Patient <input type="checkbox"/> Client	
Submitter# Unique ID or MRN		DOB-Required	Sex M F	Responsible Party (Please Print)
Patient's Phone Number ()	Collection Date & Time	Collection by- Required	Address	
Copy to: First Name Last Name		City, State, Zip		
Copy to complete address for mailing:			ICD Code(s) - REQUIRED INFORMATION	
			Physician Signature: _____	Date: _____
Time: _____				
Each individual test and CMS approved panel must have ICD code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD code(s) for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests. <i>Continued on page 2</i>				
Sample Type				
<input type="checkbox"/> Plasma	<input type="checkbox"/> Serum	<input type="checkbox"/> Urine	<input type="checkbox"/> Paraffin Block; site _____	
<input type="checkbox"/> Viral Transport Media	<input type="checkbox"/> Other; type _____	Type _____	Block No. _____	
Return block to <input type="checkbox"/> address above or address:				
Genotyping and Antiviral Resistance Testing			Test Code	Specimen
<input type="checkbox"/> Hepatitis C Virus (HCV) RNA, Quantitative PCR, Serum, with reflex to Genotyping			HCVPCX	Ø
<input type="checkbox"/> HIV-1 Antiviral Resistance Testing - Integrase, Plasma			AVIN	*
<input type="checkbox"/> HIV-1 Antiviral Resistance Testing - RT and Protease, Plasma			AVRT	*
<input type="checkbox"/> Human Papilloma Virus (HPV), 16/18 Typing			HPVPCR	PET
<input type="checkbox"/> Human Papilloma Virus (HPV), 6/11 Typing			HPV6PC	PET
<input type="checkbox"/> Human Papilloma Virus (HPV), Nucliec Acid Amplification Testing (NAAT), with reflex to HPV 16, 18/45 Genotyping			HPVHRX	LP
Viral Load			Test Code	Specimen
<input type="checkbox"/> Adenovirus DNA, Quantitative PCR, Plasma			ADVQT	*
<input type="checkbox"/> BK Virus DNA, Quantitative PCR, Plasma			BKVPC	*
<input type="checkbox"/> BK Virus DNA, Quantitative PCR, Urine			BKVPCU	U
<input type="checkbox"/> Cytomegalovirus (CMV) DNA, Quantitative PCR, Plasma			CMVQT	▲
<input type="checkbox"/> Epstein-Barr Virus (EBV) DNA, Quantitative PCR, Plasma			EBVQP	***
<input type="checkbox"/> Epstein-Barr Virus (EBV) DNA and BamHI Quantitative PCR, Plasma			EBVQPB	***
<input type="checkbox"/> Hepatitis B Virus (HBV) DNA, Quantitative PCR, Serum			HBPCR	Ø
<input type="checkbox"/> Hepatitis C Virus (HCV) RNA, Quantitative PCR, Serum			HCVPCR	Ø
<input type="checkbox"/> HIV-1 RNA, Quantitative PCR, Plasma@			HIVPCR	***
<input type="checkbox"/> Human Herpes Virus -6 (HHV-6) DNA Quantitative PCR, Plasma			HHV6QT	*
Qualitative Nucleic Acid Tests			Test Code	Specimen
<input type="checkbox"/> Adenovirus, Qualitative PCR			ADVQL	BAL, NP
<input type="checkbox"/> Cytomegalovirus (CMV) DNA, Qualitative PCR			CMVQL	BAL, T, U, PET
<input type="checkbox"/> Epstein-Barr Virus (EBV) DNA, Qualitative PCR			EBVQL	CSF, BM,T
<input type="checkbox"/> Herpes Simplex Virus (HSV) 1 and 2 DNA, Qualitative PCR, Non-Lesion			HSVQL	*, BAL, CSF
<input type="checkbox"/> Herpes Simplex Virus (HSV) & Varicella-Zoster Virus (VZV), Qualitative PCR, Lesions			HSVZL	VTM
<input type="checkbox"/> Human Herpes Virus-6 (HHV-6), Qualitative PCR			HHV6QL	CSF, BAL, BM, T
<input type="checkbox"/> Respiratory Virus Panel, PCR			RESPCR	NP
<input type="checkbox"/> Varicella-Zoster Virus (VZV) DNA, Qualitative PCR, Non-Lesion			VZVQL	*, BAL, CSF

Specimen Type	Consult Lab Guide for Specimen Handling at www.stanfordlab.com or call Customer Service at 1 (877) 717-3733
Ø	- 3 mL Serum Gold-Top/SST tube, centrifuge within 6 hours of collection. Transport refrigerated. If transport is greater than 2 days, centrifuge and transfer serum to a screw-capped tube and transport specimen frozen.
*	- 3 mL EDTA or ACD Plasma, centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
▲	- 3 mL ACD Plasma, centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
***	- 3 mL EDTA Plasma, centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
BAL	- 4-12 mL Bronchoalveolar lavage (BAL) fluid in a sterile container. Transport refrigerated. If transport is greater than 2 days, transport frozen.
BM	-4 mL Bone Marrow in Lavender-top tube (EDTA) or a Light-blue-top tube (sodium citrate) or Yellow-top tube Acid Citrate Dextrose Solution A (ACD), transport refrigerated.
CSF	- 3 mL CSF in sterile, leak-proof container, transport refrigerated unless transport will be greater than 4 hours then transport frozen.
LP	- 4 mL ThinPrep® Liquid Based Pap. Transport at room temperature.
NP	- 1 nasopharyngeal (NP) flocked swab in Viral Transport Media (4MRT). Transport refrigerated. If transport is greater than 2 days, transport frozen.
PET	- 3 to 5 paraffin-embedded tissue scrolls at 5-10 µm thickness in a screw cap tube. Transport at room temperature.
T	- 5 mm ³ tissue, transport refrigerated.
U	- 2 mL Urine, transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
VTM	- 1 flocked or Dacron swab in Viral Transport Media (4MRT). Transport refrigerated. If transport is greater than 2 days, transport frozen.

Ship to:
Stanford Anatomic Pathology and Clinical Laboratories
Attn: Specimen Processing
3375 Hillview Ave
Palo Alto, CA 94304
Phone: 1 (877) 717-3733

If shipping Friday check for Saturday delivery

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

Continued from page 1

Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of any illness or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. @ This test is subject to Medicare NCD or LCD, coverage is limited to certain diagnoses that support medical necessity.

Patient's First Name: _____

Patient's Last Name: _____

Patient's MRN: _____

Or Affix Label Here



Stanford
HEALTH CARE
STANFORD MEDICINE

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** 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.** below.

D.	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.** 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.** 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.** 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.** 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.

I. Signature:	J. Date:

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.