CLINICAL MICROBIOLOGY

Stanford HEALTH CARE
STANFORD MEDICINE

3375 Hillview Ave • Attn: Specimen Processing • Palo Alto, CA 94304
Phone: 1 (877) 717-3733
www.stanfordlab.com
Christina Kong, M.D. - Medical Director Anatomic Pathology & Clinical Laboratories • Niaz Banaei, M.D. - Director, Clinical Microbiology

Patient Information

Patient Name (Last) (First) | Date of Birth

Referring Facility MRN | Sex M F | Patient's Phone Number ( )

Patient Address | City | State | Zip Code

Collection Date: (REQUIRED)

Requestor Information

Practice/Facility Name & Address

Phone No. | Fax No.

BILL TO: ABN is Located on Last Page

❑ Patient ❑ PPO ❑ HMO* ❑ Client ❑ Medicare ❑ Outpatient ❑ Inpatient

HMO Insurance Authorization # ____________________

**Referring facility is responsible for obtaining HMO authorization. If claim is denied due for lack of authorization, the referring facility will be billed for services.*

Insurance Information: Attach a copy of front & back of insurance card or face sheet.

Technical (lab) and professional (M.D. charges are billed separately.

Each CMS approved test and panel must have ICD code(s) to indicate the medical necessity of the test requested. 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.

Shippers Responsibility: The shipper is required to comply with the rules for transport of medical specimens 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 Health Care will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

For Lab Use Only

Submission of samples constitute the acceptance of the Terms and Conditions for Stanford Clinical Laboratory Testing and Anatomic Pathology Services. Terms & Conditions can be referenced on www.stanfordlab.com.

REQUIRED INFORMATION **ICD Codes(s)**

Requesting Physician

Physician Name | Date | Physician NPI #: | ***Physician Signature - REQUIRED***

COPY TO: (Name & Address, Fax & Phone)

TESTING REQUESTED

For assay details and specimen requirements, refer to next page and www.stanfordlab.com

SAMPLE TYPE

Referring Facility Specimen ID: ____________________

- ❑ Fresh Tissue - Source: ____________________
  Accepted for: BACIDS, TBPCRS, FUNIDS, MOLDPCR, DMFPCT, CANPCR, MACPCR
- ❑ Paraffin embedded tissue (block/scrolls) Please attach a copy of the pathology report.
  Accepted for: BACIDS, TBPCRS, FUNIDS, MOLDPCR , DMFPCR, CANPCR, MACPCR
  Source: ____________________ Block #: ____________________
- ❑ Sterile Body Fluid - Source: ____________________
  Accepted for: BACIDS, TBPCRS, FUNIDS, MOLDPCR, DMFPCR, CANPCR, NOCPCR, MACPCR, LEGPCR, MENPCR (CSF ONLY)
- ❑ Plasma
  Accepted for: BACIDS, TBPCRS, FUNIDS, MOLDPCR, DMFPCR, CANPCR, PJPCR, NOCPCR, LEGPCR
- ❑ Bronchoalveolar lavage
  Accepted for: TBPCRS, MOLDPCR, DMFPCR, PJPCR, LEGPCR, NOCPCR
- ❑ Sputum
  Accepted for: TBPCRS, LEGPCR, PJPCR, NOCPCR
- ❑ Isolated colony on an agar slant *Accepted for:* FUNIDI, BACIDI
- ❑ EDTA blood *Accepted for:* GFEVER
- ❑ Stool in Cary Blair media *Accepted for:* GIPCR
- ❑ Vaginal swab *Accepted for:* VAGPCR

TESTING REQUESTED

TESTING REQUESTED	CODE
❑ Bacterial ID by Sequencing from Specimen	BACIDS
❑ Bacterial ID from Isolate	BACIDI
❑ Mycobacterium tuberculosis PCR from Specimen	TBPCRS
❑ Mycobacterium avium complex PCR	MACPCR
❑ Nocardia PCR	NOCPCR
❑ Legionella PCR	LEGPCR
❑ Fungal ID by Sequencing from Specimen	FUNIDS
❑ Fungal ID from Isolate	FUNIDI
❑ Mold Panel PCR	MOLDPCR
❑ Dimorphic Fungi PCR	DMFPCR
❑ Candida species PCR	CANPCR
❑ Pneumocystis jirovecii PCR	PJPCR
❑ Global Fever Panel	GFEVER
❑ Gastroenteritis PCR Panel with Reflex	GIPCR
❑ Meningitis/Encephalitis PCR Panel	MENPCR
❑ Vaginosis Panel PCR	VAGPCR
❑ Other, specify:	

Clinical History and Suspected Diagnosis:

Block Returns:
Facility:
Address:

A. **Notifier:**
B. **Patient Name:** C. **Identification Number:**

Advance Beneficiary Notice of Non-coverage (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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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.