Stanford HEALTH CARE
STANFORD MEDICINE

Anatomic Pathology and Clinical Laboratories
Customer Service Toll Free (877) 717-3733

Biochemical Genetics

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 ❑ Private Ins/PPO ❑ Medicare ❑ Medi-Cal ❑ Patient ❑ Client
Client Acct # Unique ID or MRN	DOB-Required MM/DD/YYYY	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.

TEST NAME	TEST CODE	SPECIMEN
❑ Acylcarnitine Profile, Plasma (Quantitative)	LABACYLP	*
❑ Amino Acids, CSF (Quantitative)	LABAACSF	*
❑ Amino Acids, Serum (Quantitative)	LABAAP	*
❑ Amino Acids, Urine (Quantitative)	LABAAUR	*
❑ Amino Acids, Blood Spot **(Not for initial diagnosis, for monitoring only)**	LABAABS	Filter Card
❑ Biotindase, Serum	LABBTDASE	*
❑ Carnitine, Free and Total, Serum (Quantitative)	LABCARN	*
❑ Carnitine, Free and Total, Urine (Quantitative)	LABUCARN	*
❑ Creatine Disorder Panel, Plasma	LABCDPP	*
❑ Creatine Disorder Panel, Urine	LABCDPU	*
❑ Glutathione, GSH and GSSG, Whole Blood (Quantitative) **NOTE: Must be received by BCG within 24 hours of draw. Immediately refrigerate whole blood or put on ice pack. Do not freeze. No weekend deliveries without prior arrangement with the Medical Director. Sample must be received by noon on Fridays.**	LAB274	■
❑ Methylmalonic Acid, Serum (Quantitative)	LABMMAS	*
❑ Mucopolysaccharides, Urine (Quantitative)	LABMPSQNT	*
❑ Mucopolysaccharides, TLC, Urine	LABMPSTLC	*
❑ Oligosaccharides, Mass Spectrometry, Urine (Qualitative)	LABOSLCMS	*
❑ Organic Acids, Urine (Qualitative)	LABUORG	*
❑ Orotic Acid, Urine (Quantitative)	LABUOROT	*
❑ Sulfocysteine, Plasma	LABSLFCP	*
❑ Sulfocysteine, Urine	LABSLFCU	*

*Frozen sample, transport frozen. **Card:** Dried Blood Spot Collection Device provided by testing laboratory.

■ Keep cool during transport. Do not freeze.

Consult test directory for specimen handling at www.stanfordlab.com or call Customer Service at 1 (877) 717-3733

Ship to:
Stanford Anatomic Pathology and Clinical Laboratory
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 Health Care Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

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:

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