❒ 3520 Progress Drive, Suite C / Bensalem, PA 19020 / 267-525-2470 / Fax 267-525-2488

# Atlantic Diagnostic Laboratories, LLC

DRAW SITE:

15072592

MUST ALWAYS BE COMPLETED

**CLIENT INFORMATION**

Account# 116
FAMILY HOUSE NOW PHILADELPHIA
1020 N 48TH ST
PHILADELPHIA, PA 19131
215-878-8616

SPECIMEN DATE: 11/21/19
TIME: _____ ❒ a.m. ❒ p.m.

| PATIENT'S LAST NAME | FIRST N | | | |
|---|---|---|---|---|
| Bowen | Brandi | | | |
| **PATIENT'S SOCIAL SECURITY NO.** | **AGE** | **SEX** | **DATE OF BIRTH** | |
| 161-96-1824 | | F | 6 14 85 | |

| ICD-10 CODES | DIAGNOSIS | ICD-10 CODES | DIAGNOSIS |
|---|---|---|---|
| | | | |
| | | | |

Physician's or Authorized Signature

PATIENTS ADDRESS (Street, City, State, Zip Code)

TELEPHONE NUMBER ( ) -

Bill To: ❒ MEDICARE ❒ MEDICAID ☒ CLIENT ❒ PATIENT ❒ HMO ❒ OTHER INS.

MEDICAID #/MEDICARE #/INSURANCE POLICY #.

MEMBER I.D. # | GROUP #

**Required by CMS – Medicaid and Medicare**
**Diagnosis Code(s) Mark Test(s) Ordered Date and Time of Collection**
**PATIENT SIGNATURE and Date, Full Name, DOB, SS#, Sex**
**PHYSICIANS SIGNATURE (NO STAMPS OR PHOTO COPIES)**

Comments:

check for CATAPRES

(X) DAU 29
(ALC,AMP,BARB,BENZO,BUP,COC,FENTANYL,METHADONE,
OPI,OXY,PCP,THC,PH,SPCGRVTY,CREAT)

( ) ORAL 82 (SEE BACK)

**CMS requires that physicians shall only order tests that are medically necessary for the diagnosis and treatment of this patient.**

| AMA PANELS • See reverse for components | | | |
|---|---|---|---|
| 510 | | Basic Metabolic Panel | SST |
| 540 | | Comp. Metabolic Panel | SST |
| 50 | | Electrolyte Panel | SST |
| 71 | | Hepatic Function Panel | SST |
| 7040 | | ***CBC WITH DIFF/PLATELET*** | L |
| 560 | | * Lipid Profile Panel | SST |
| | | | |
| | | | |

| ALPHABETICAL LISTING INDIVIDUAL TESTS | | | |
|---|---|---|---|
| 237 | | Amylase | SST |
| 218 | | * GGT | SST |
| 809 | | **** HEMOGLOBIN A1C*** | L |
| 1114 | | Hepatitis A AB (IGM) | SST |
| 1120 | | Hepatitis B Core (IGG/IGM AB) | SST |
| 824 | | Hepatitis B Surface AG | SST |
| 826 | | Hepatitis C AB | SST |
| 865 | | HIV 4th Gen | SST |
| 840 | | Lead, Blood | L |
| 811 | | Lipase | SST |
| 236 | | **** MAGNESIUM*** | SST |
| 814 | | Prolactin | SST |
| 628 | | Syphillis Screen | SST |
| 828 | | RPR | SST |
| 741 | | Sickel Cell Screen | L |
| 233 | | **** T3 UPTAKE*** | SST |
| 229 | | **** T4, TOTAL*** | SST |
| 819 | | **** TSH*** | SST |
| 717 | | Urinalysis w/Microscopic | U |
| 735 | | Urine Pregnancy | U |
| | | | |
| | | | |

Tests not listed on form are not covered by CBH, CCBH or Magellan

| DRUG LEVELS | | | |
|---|---|---|---|
| 209 | | Carbamazepine (Tegretol) | R |
| 50169 | | Desipramine/Imipramine | R |
| 821 | | Lithium | R |
| 867 | | Nortriptyline / Aventyl | R |
| 223 | | Phenobarbital | R |
| 224 | | Phenytoin (Dilantin) | R |
| 871 | | Primidone (Mysoline) | R |
| 235 | | Valproic Acid (Depakene) | R |
| | | | |
| | | | |
| | | | |

| DRUGS OF ABUSE SEE REVERSE FOR COMPONENTS. | | | |
|---|---|---|---|
| 83 | | Oral Drug Screen (5 Drugs) | |
| 91 | | Oral Drug Screen (8 Drugs) | |
| 400 | | Urine Alcohol | U |
| 9 | | Drugs of Abuse (9 Drugs) w/Alc | U |
| 5 | | Drugs of Abuse (5 Drugs) | U |
| 38 | | Drugs of Abuse (9 Drugs) | U |
| 1 | | Drugs of Abuse (11 Drugs) w/Alc | U |

**** COVERED UNDER "LIMITED COVERAGE POLICY" OF MEDICARE – PLEASE INCLUDE RELEVANT DIAGNOSIS CODES***

I authorize the release of any medical information to process the service listed above, authorize ADL to bill my insurance for services described above and authorize my insurance carrier to pay ADL directly. I assume responsibility for payment of any and all co-pays and deductibles that may be applied to the services described above. I assume full responsibility for payment of services that are not covered by my insurance carrier.

❒ By Checking this box, ~~I do not~~ want my insurance carrier billed for services described above. I assume responsibility for payment of all service listed above that are billed to me by ADL

Patient Signature _____ Date 11/21/19 Phlebotomist Intials _____ Date _____