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Blood Work Profile

Lab Director: Maher Albitar, MD
CLIA: 01D0641541

PLEASE COMPLETE ALL HIGHLIGHTED AREAS IN THEIR ENTIRETY.

Patient Information

Last Name First Name Middle Name

Address

City State Zip Code

/ / M I F ()

Date of Birth Gender Phone Number Last 4 Digits of SSN

Billing Information—Check only one.

☐ **Patient's insurance or Medicare:** Copy both side of insurance/Medicare card(s) and attach to requisition. (NOTE: Indicate primary and secondary insurance).

☐ **Self Pay:** VAP Diagnostics Lab will bill patient directly.

/ / : am | pm Yes No

Draw Date Draw Time Client ID/Specimen # 12 Hr. Fasting

Lab Use Only

Requesting Physician, Lab, or Institution

Physician Signature: _____

		GC/ Chlamydia	HIV 1&2	Syphilis	UA	Pregnancy	Glucose	2 HR GTT	LFT	Lipid Panel	CBC w/ diff	Hemoglobin	Hematocrit	Cholesterol	BX
1	<input type="checkbox"/> V25.01														
	<input type="checkbox"/> V25.41														
2	<input type="checkbox"/> V25.9														
	<input type="checkbox"/> V25.40														
3	<input type="checkbox"/> V25.5														
	<input type="checkbox"/> V25.40														
4	<input type="checkbox"/> V25.11														
	<input type="checkbox"/> V25.42														
5	<input type="checkbox"/> V25.02														
	<input type="checkbox"/> V25.49														
6	<input type="checkbox"/> V25.41														
	<input type="checkbox"/> V72.42														
7	<input type="checkbox"/> V25.09														
	<input type="checkbox"/> V25.2														

Secondary Diagnosis (ICD9/10) required on the F. Pact. Test(s)

- * Wet Mount & Vaginal Beta Strep—112.1, 616.10, V01.6
- * CBC—614.0, 614.2, 615.0
- * Urinalysis—595.0, 788.1
- * GC/CT—V01.6, V02.8, V69.2, V120.9, V73.88, V74.5

PE Panel

- ☐ V22 ☐ V22.1 ☐ V22.2 ☐ OBP ☐ CT/GC ☐ UDS ☐ Urine Culture ☐ HCG Qual/Quant. ☐ HIV 1&2
- ☐ Lead Level ☐ 1hr GTT 50gm ☐ 3hr GTT 100gm
- ☐ GC/Chla

Additional ICD-10 Codes

- ☐ A59.0 ☐ A59.03 ☐ N76.0 ☐ Z20.0 ☐ Z30.011 ☐ Z30.013 ☐ Z30.015 ☐ Z30.016 ☐ Z30.017 ☐ Z39.018
- ☐ Z30.41 ☐ Z30.42 ☐ Z30.430 ☐ Z30.430 ☐ Z30.432 ☐ Z30.433 ☐ Z30.44 ☐ Z30.45 ☐ Z30.46 ☐ Z30.49 ☐ Z98.51

Medicare will only pay for tests that meet the Medicare criteria and are reasonable and necessary to treat or diagnose an individual patient. Patient's Signature: _____

Every Women Counts

Only Pap smears, biopsies, FNA Interpretations, Level IV, Level V w/ BX are payable under this program with the following diagnosis: V72.31, V76.2, 616.0, 622.10-622.12, 795.00-795.19

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.

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.**

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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