



Fairview Diagnostic Laboratories

TEST ORDER / SPECIMEN REGISTRATION

This form must be completed **entirely** and accompany all specimens brought to laboratory for testing.

COLLECTION DATE:	TIME COLLECTED:	COLLECTED BY:
<input type="checkbox"/> SERUM <input type="checkbox"/> PLASMA <input type="checkbox"/> WHOLE BLOOD <input type="checkbox"/> URINE, RANDOM <input type="checkbox"/> 24 HR URINE VOL _____ mL <input type="checkbox"/> OTHER _____		
<input type="checkbox"/> FASTING <input type="checkbox"/> NON-FASTING _____ hrs PP <input type="checkbox"/> URINE		
Routine test reports will be transmitted electronically(daily), according to Billing / Reporting Instructions selected below. <input type="checkbox"/> STAT results should be called to: _____ <input type="checkbox"/> Fax Back# for STAT results: _____		

COMMENTS / INSTRUCTIONS:

FACILITY		PHONE
CITY-STATE-ZIP		
Account #		
PATIENT NAME (LAST, FIRST, MI)		
I.D. NUMBER	BIRTHDATE	<input type="checkbox"/> Male <input type="checkbox"/> Female
PHYSICIAN (L,F,MI):		
NPI:		
Bill To: <input type="checkbox"/> Insurance - Attach information <input type="checkbox"/> Clinic Account <input type="checkbox"/> Patient Billing Information: Complete information must be provided or Clinic will be billed. If more than one payer, clearly specify primary insurance.		

Lab Tests Ordered:	"If the patient is on Medicare, Medical Assistance or you request us to bill insurance you MUST COMPLETE an ICD-9 code for each test requested before testing can be performed."		ABN: Tests ordered on Medicare patients must comply with medical necessity guidelines and must include ICD9 Coding, diagnosis, symptoms, or the reason for testing. If tests do not meet Medicare guidelines for payment, an Advanced Beneficiary Notice signed by the patient prior to specimen collection <u>must be included</u> .
	ICD-9 Code / Diagnosis:		
	<input type="checkbox"/> Routine	Signed	
	<input type="checkbox"/> STAT	<input type="checkbox"/> ABN	
	<input type="checkbox"/> Routine	Signed	
	<input type="checkbox"/> STAT	<input type="checkbox"/> ABN	
<input type="checkbox"/> Routine	Signed		
<input type="checkbox"/> STAT	<input type="checkbox"/> ABN		
<input type="checkbox"/> Routine	Signed		
<input type="checkbox"/> STAT	<input type="checkbox"/> ABN		
<input type="checkbox"/> Routine	Signed		
<input type="checkbox"/> STAT	<input type="checkbox"/> ABN		

FAIRVIEW LAKES REGION MEDICAL CTR
5200 FAIRVIEW BLVD.
WYOMING, MN 55092
651-982-7200

FAIRVIEW RED WING HOSPITAL
701 FAIRVIEW BLVD.
RED WING, MN 55066
651-267-5271

FAIRVIEW SOUTHDAL HOSPITAL
6401 FRANCE AVE. SO.
EDINA, MN 55435
952-924-5140

UNIVERSITY OF MN MED CENTER
• RIVERSIDE CAMPUS
2450 RIVERSIDE AVE. SO.
MINNEAPOLIS, MN 55454
612-273-6135

FAIRVIEW NORTHLAND REGIONAL HOSPITAL
911 NORTHLAND DRIVE
PRINCETON, MN 55371
763-389-6391

FAIRVIEW RIDGES HOSPITAL
201 E. NICOLLET BLVD.
BURNSVILLE, MN 55337
952-892-2085

FAIRVIEW-UNIVERSITY MED CENTER-MESBI
750 E. 34TH ST
HIBBING, MN 55746
218-362-6625

• UNIVERSITY CAMPUS
420 DELAWARE ST SE MMC198
MINNEAPOLIS, MN 55455
612-273-7838

Fairview Laboratory staff use only

HID "F" Charge to:

_____, _____

String them in order using comas (no spaces) ex: aa,aa,aa.

Medicare does not cover items or services which are not reasonable or necessary for the diagnosis or treatment of an illness or injury. To be covered, claims must document the symptom, injury, illness or complaint for which a diagnostic test is performed. **The ordering physician is required to provide the appropriate reason for which the test(s) is ordered.**

FOR RECEIVING USE ONLY	INITIALS	ACCN#	PT ID
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