

# Manual request completion instructions

## Billing indications and requirements

If you wish us to **bill your clinic or facility**, complete the following sections of the request form:

1. You **MUST MARK** "CLIENT"
3. Date & time collected
4. Gender
5. Birth date
6. Patient's name (Last, First MI)
8. Patient's address - Street & city
9. Patient's address - State & Zip
10. Patient's telephone number
21. Ordering provider

If you wish us to **bill the patient directly**, complete the following sections of the request form:

2. You **MUST** mark "PATIENT/INSURANCE"
3. Date & time Collected
4. Gender
5. Birth date
6. Patient's name (Last, First MI)
8. Patient's address - Street & city
9. Patient's address - State & Zip
10. Patient's telephone number
14. Policy Holder (If Not Patient); also used for Guarantor if patient is under 18 years of age. If different, please list.
20. Diagnosis\*
21. Ordering provider

If you wish us to **bill Medicare, Medicaid or other third-party payers**, we must have the following sections of the request form completed:

2. You **MUST** mark "PATIENT/INSURANCE"
3. Date & time collected
4. Gender
5. Birth date
6. Patient's name (Last, First MI)
8. Patient's address (Street & city)
9. State & Zip
10. Patient's telephone number
11. For Medicare patients only, the appropriate box on the requisition should be checked to indicate if Medicare is Primary or Secondary.
12. Medicare #
13. Medical Assistance # and state in which it was issued
14. Policy Holder (If Not Patient); also used for Guarantor if patient is under 18 years of age. If different, please list
15. Policy Holder's Date of Birth
16. Member/Policy #
17. Group #
18. Relationship of Patient to Insured
19. Insurance Company Name
20. Diagnosis\*
21. Ordering Provider

\*ICD codes or clear diagnostic symptom descriptions are required to the highest specificity.

 *LAB02*	ALLINA HEALTH LABORATORY CLINICAL REQUEST 2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407 Phone: 612-863-4678 • Fax: 612-863-4067 www.allinahealth.org/laboratory	<b>BILL TO (MUST CHECK ONE):</b> <input type="checkbox"/> CLIENT <input type="checkbox"/> PATIENT/INSURANCE	
	<small><input type="checkbox"/> MEDICARE SECONDARY PAYER (MSP) INFORMATION REQUIRED. (INTERNAL USE ONLY) MSP status has been verified with beneficiary or representative within 90 days of service and documentation is on file. <input type="checkbox"/> MSP Collected</small>		
DATE & TIME COLLECTED <b>3</b>		DRAWN BY	
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <b>4</b>		BIRTH DATE (mm-dd-yyyy) <b>5</b>	
PATIENT NAME: Last, First MI <b>6</b>		CHART # <b>7</b>	
PATIENT ADDRESS: Street and City <b>8</b>			
STATE <b>9</b> ZIP		PATIENT PHONE <b>10</b>	
<input type="checkbox"/> MEDICARE PRIMARY <input type="checkbox"/> MEDICARE SECONDARY <b>11</b>			
MEDICARE <b>12</b>			
MEDICAL ASSISTANCE NUMBER <b>13</b>		STATE	
INSURANCE CO. NAME <b>19</b>		RELATIONSHIP OF PATIENT TO INSURED <b>18</b>	
POLICY HOLDER'S NAME <b>14</b>		POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) <b>15</b>	
SUBSCRIBER ID # <b>16</b>		GROUP # <b>17</b>	
<input type="checkbox"/> STAT All or Single test <input type="checkbox"/> Call to <b>22</b> ( )		Dx1 <b>20</b> Dx3 PROVIDER SIGNATURE Dx2 Dx4 REFERRING PROVIDER	
Additional Tests		<small> <input type="checkbox"/> ABN NOT INDICATED  <input type="checkbox"/> ABN INCLUDED                      *Indicates coverage sensitive tests, ABN may be needed.                 </small>	
<small>                     Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines, and must include diagnosis, symptom, or reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment, a "signed" Advanced Beneficiary Notice must be included. Clinical consultation regarding test ordering is provided at 612-863-4670.                 </small>			

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## Additional information:

Item #	Notes
1 & 2	If the request comes in with a sample to Allina Health Laboratory with no bill type marked, the default is to bill the clinic. If the patient presents at one of our draw sites and no bill type is marked, the default is to bill patient/insurance.
6	Patient's full legal name, no nicknames, etc. This must match what insurance has on file for the patient or they will reject the claim.
7	Your chart number is optional. If supplied, it will appear on your patient report.
8 - 10	Patient's current and complete mailing address and phone number.
11	One of the two boxes must be marked when Medicare is listed along with another insurance company.
12	Medicare number and the suffix is required if Allina Health Laboratory is to bill Medicare. Simply using the patient's SSN is not accurate or complete.
14 - 15	This is the person that holds the insurance policy. For minors this is also the Guarantor, so Allina Health Laboratory can bill out the claim if needed.
16 - 17	This should be the full complete insurance company identification number. Often the group number is listed separately so that must be included.
18	Check the relationship between the patient and the policy holder.
19	List the full name of the insurance company and no abbreviations. If we cannot determine what this is, we will send a letter asking for more information.
20	Diagnosis is REQUIRED*. <b>This cannot be a "rule out" or the word "screen"</b> . We need the specific information as to why the tests were ordered. Often the codes must have a 4th and even 5th digit in order to bill out for the laboratory services.
21	The ordering provider must be indicated; 1. If preprinted, circle the name and Allina Health Provider ID number on the request form 2. If the provider is not preprinted on the request form: a. If you know the ordering providers Allina Health Provider ID number, write the number and full name. b. If you do not know the providers Allina Health Provider ID number, write the providers full name, credentials and National Provider Identifier (NPI) number.
22	If the testing is STAT, or you need the results called, indicate that here. Results will only be faxed to the requesting location.