Orange Coast Medical Center 9920 Talbert Ave. Fountain Valley, CA 92708 (714)378-7800

LABORATORY REQUEST

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REMINDER: DON'T FORGET 2 IDENTIFIERS LAST & FIRST NAME AND DATE OF BIRTH

MemorialCare. Orange Coast Medical Center

ORDER DATE: _____ TIME: _____

DID YOU REMEMBER... TO INCLUDE DIAGNOSIS CODE(S)?

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED OR CLIENT ACCOUNT MAY BE BILLED.

COMPLETE FOR ALL BILLING TYPES (Please attach a copy of MEDI-CARE or Insurance Card)

PATIENT INFO

PATIENT NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH M M / D D / YEAR | AGE | SEX

PATIENT PHONE: ( )

STREET ADDRESS OF INSURED/RESPONSIBLE PARTY

CITY | STATE | ZIP

ORDERING PHYSICIAN**

BILL TO:
- ☐ CLIENT/PHYSICIAN
- ☐ PATIENT
- ☐ CASH PAY
- ☐ MEDICARE (ABN ?)
- ☐ MEDICAID
- ☐ OTHER INSURANCE
- ☐ WORKMAN'S COMP

- ☐ DROP OFF
- ☐ PRE-OP
- ☐ FASTING
- ☐ NON-FASTING

LAB SERVICE LOCATIONS

Orange Coast Medical Center
9920 Talbert Ave
Fountain Valley, CA 92708
Laboratory: (714) 378-7800

STAT

☐ **STAT - CALL** _____ **OR FAX** _____ ☐ DURING OFFICE HOURS ONLY TO:

☐ **PHONE #** _____ ☐ **FAX #** _____

INSURANCE

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

DATE OF BIRTH M M / D D / YEAR

INSURANCE PTS. ONLY The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the terms of the hospital. The balance unpaid more than 30 days after presentation of the discharge bill or as mutually agreed by third part contract are considered delinquent. Should the account be referred to an attorney for collection the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the rate set by California state law.

****The ordering physician authorizes release of results to Memorial Health System's hospital patient record and subsequently to the patient if requested.**

PATIENT/PARENT/GUARDIAN/CONSERVATOR _____ DATE _____

DATE/TIME COLLECTED: By _____

Diagnosis(es) or Signs/Symptoms for each test: REQUIRED

TESTS	DX CODE
[ ] Bilirubin Total and Direct	_____

ATTN: Registration – Set Patient Class to Specimen

[ ] BILL PATIENT INSURANCE

ICD-10 / DIAGNOSIS * *

1. _____
2. _____
3. _____

Person authorized to release Diagnosis information: _____

LAV _____ ROYAL _____ GRN _____ UA CUP _____ 7 mL RED _____ GRAY _____ BLUE _____ SST _____

YEL _____ SWAB _____ VIRAL TRANSPORT _____ FRESH STOOL _____ STOOL TRANSPORT _____ FROZEN _____

SPUTUM _____ FIOBT _____ OTHER _____

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PATHOLOGISTS
Dr. Julio Ibarra

CLIA No. 05D0669704

ADVANCE BENEFICIARY NOTICE

Medicare will only pay for services that it determines to be medically reasonable and necessary under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular test, although it would otherwise be covered, "is not reasonable and necessary", under the Medicare Program Standards, Medicare will deny payment.

Tests ordered by your physician which are likely to be denied for payment should be identified by the * symbol. By signing the separate acknowledgement form you are agreeing to be financially responsible for payment.