Tests Requisition Form

Please print clearly and complete all parts of this form. (You may attach a completed Super Bill and/or a photocopy of both sides of the patient's insurance card and driver's license to supply that portion of the information which is required.)

Patient Information

Patient Name: Last First Middle

Address:

City: **State:** **Zip:**

Date of Birth: **Gender:** M | F

Client No.

Account Information

Account:

10218 University of California San Francisco Medical Center Clinical Laboratory

☐ ☐ ☐
☐ ☐ ☐

185 Berry Street Suite 290

City: San Francisco **State:** CA **Zip:** 94107

Phone #: 415 353 1349 **Contact:**

Specimen Information

Draw Date Specimen number Fasting Y | N

Billing Information

☐ Insurance ☐ Patient ☐ Physician

Reminder:
- ☐ Have patient sign Release of Benefits below.
- ☐ Copy both sides of the patient's insurance card(s).
- ☐ Indicate primary and secondary diagnoses.

Physicians should only order tests that are medically necessary and reasonable for the diagnosis or treatment of a Medicare or Medicaid patient for which reimbursement is claimed.

Genotype testing can be complex. Physicians may advise patients to seek professional genetic counseling to fully understand the benefits and limitations. Informed consent is recommended and may be required for patients according to some state laws. Consent forms are available from Atherotech, Inc. upon request.

Private Pay Option

☐ Check: Make Payable to Atherotech, Inc. ☐VISA ☐MasterCard ☐AMEX

Name on the Card:______________________________

Expiration Date:__________ CC Number:____________________

Signature:________________________ Amount:$__________

Release and Assignment of Benefits

I authorize Atherotech to release to Medicare or its Carriers and any insurance carrier providing medical benefits to me and any health plan of which I am a member any medical or other information needed for claim payment purposes. I authorize payment of Medical Insurance Benefits to the party who bills for this claim and accepts assignment.

Bill to my insurance: I understand that if my insurance carrier denies payment, or applies an amount to the deductible/co payment, I am responsible for these charges.

Important: Insurance regulations require Atherotech to seek payment.

I permit a copy of this authorization to be in place of the original.

X____
Patient's Signature Date

All Patients Must Sign For Insurance Authorization

Test(s) Selection

The VAP Test includes a direct measured triglyceride value obtained by a separate enzymatic test. CPT Codes used for billing Medicare and third-party payors are as follows:

Individual Test CPT	Sample Type
~~☐ VAP and Triglycerides (83701 and 84478)~~	~~Serum~~
~~☐ Apo E genotype (83891, 83892, 83896, 83903, 83908, 83912)~~	~~Whole Blood~~
~~☐ ALT (84460)~~	~~Serum~~
~~☐ AST (84450)~~	~~Serum~~
~~☐ Creatinine (82565)~~	~~Serum~~
~~☐ Creatine Kinase (CK) (82550)~~	~~Serum~~
~~☐ C-Reactive Protein *hs* (86141)~~	~~Serum~~
~~☐ Cystatin C (82610)~~	~~Serum~~
~~☐ Glucose (82947)~~	~~Serum~~
~~☐ HbA1c (83036)~~	~~Whole Blood~~
~~☐ Homocysteine (83090)~~	~~Serum~~
~~☐ Insulin (83525)~~	~~Serum~~
☐ Lp-PLA$_2$ (83698)	Serum
~~☐ *NT-proBNP (83880)~~	~~Serum~~
~~☐ TSH (84443)~~	~~Serum~~
~~☐ Urea Nitrogen (BUN) (84520)~~	~~Serum~~
~~☐ Vitamin D (82652) - Separate SST Required~~	~~Serum~~

*Note:
NT-proBNP may require additional ICD-9 coding

As an aid in selecting a code, below is a list of the common diagnosis codes associated with CVD risk testing, not to be viewed as the complete list. Please refer to the ICD-9 Code Book when making your diagnosis and use the ICD-9 code(s) that most accurately describes the patient's condition regardless of its inclusion on this requisition.

Please mark the appropriate Clinical Diagnosis:	ICD-9
☐ Unspecified Hypothyroidism	244.9
☐ Diabetes Mellitus uncomplicated, type II /unspec., controlled	250.00
☐ Diabetes Mellitus uncomplicated, type I/juvenile, controlled	250.01
☐ Pure Hypercholesterolemia	272.0
☐ Pure Hyperglyceridemia	272.1
☐ Mixed Hyperlipidemia	272.2
☐ Hyperchylomicronemia	272.3
☐ Other and Unspecified Hyperlipidemia	272.4
☐ Lipoprotein Deficiencies	272.5
☐ Lipidystrophy	272.6
☐ Lipidoses	272.7
☐ Other Disorders of Lipoid Metabolism	272.8
☐ Unspecified Disorder of Lipoid Metabolism	272.9
☐ Essential Hypertension Unspecified	401.9
☐ Hypertensive heart disease	402.__
☐ Hypertensive heart and chronic kidney disease	404.__
☐ Intermediate coronary syndrome	411.1
☐ Coronary Atherosclerosis Unspecified Vessel, Native or Graft	414.00
☐ Heart failure	428.__
☐ Other respiratory and chest symptoms	786.__

Other____________________________________

Diagnosis: Please use fourth and fifth digit modifiers