CHI Health Laboratory
Creighton University Medical Center- Bergan Mercy
7500 Mercy Rd
Omaha, NE 68124
Phone: 402-717-5227 Fax: 402-717-5252

CHI Health
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General Lab Requisition Completion

To ensure quality service it is imperative to complete the fields on the requisition completely and accurately.

TOP HALF OF CHI HEALTH LABORATORY GENERAL REF LAB REQUISITION

1. **Patient's Legal Name**: Please print last name, first name, and middle Initial. Middle initial is imperative to ensure selection of the correct person.

2. **Patient's Social Security Number:** Needed if available for correct identification.

3. **Patient's Date of Birth**: Format acceptable is Month, Day, Year.

4. **Patient's Sex**: M or F Mark X in appropriate box.

5. **Patient Phone No.**: Phone no. will appear on the patient's lab report to aid physician contacting patient.

6. **Patient I.D.**: This field is for your clinic medical record/chart number and will print on report.

7. **Physician #1**: Print attending physician's last name, first name.

8. **Physician #2**: For copy to another provider print physician's last name, first name.

9. **Date Collected**: Format is Month, Day, Year.

10. **Time Collected**: Use Military time (i.e. 0900, 1400) or standard time (9:10 AM/ 3PM).

11. **Collected BY**: Print first Initial and full last name (i.e. S. Jones).

12. **Patient ICD10 CODE (Diagnosis)**: If requested by the clinic to bill the patient or the patient's insurance company, valid numeric ICD10 code(s) **MUST** be provided. Medical Necessity for National Coverage Decision tests must be checked. There is enough space to provide 4 ICD10 codes. Acceptable format is an alphanumeric coded diagnosis (i.e. R87.9). Narrative or descriptive codes will not be accepted.

13. **Bill to**: The client **MUST** identify Bill Type. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance (refer to contract guidelines). Medicare/Medicaid and their products require testing to be billed by the performing lab. If we are to bill the patient, insurance

information **MUST** be filled out on form or a demographic sheet attached. A copy of the front and back of the insurance card is required.

14. **Responsible Party Information:** Please complete the responsible party information by checking the box for the relationship to the patient. Also complete the address and SSN# of responsible (Insured) party.

15. **Insurance Information Required:**

PRIMARY Insurance: Name of Insurance Company
Policy #:
Group #:

Address of Payer

SECONDARY Insurance: Name of Insurance Company
Policy #:
Group #:

Address of Payer

THE BOTTOM HALF OF THE CHI HEALTH LABORATORY GENERAL REF LAB REQUISITION:

1. **Medicare Limited Coverage Tests (NCDs):** are printed in **RED.** Refer to your NCD education for covered ICD10 codes**.** If none of the codes are acceptable the requisition must be accompanied by an ABN waiver (**Advanced Beneficiary Notice**) signed by the patient PRIOR to the service being performed. Please acknowledge whether a waiver has been signed and attach to the requisition.

2. **Tests:** Listed are the most common tests with appropriate CPT Code for CHI Health Lab. The AMA (American Medical Association) approved panels are listed first on the left hand side. All other tests are listed under the subtopics of THYROID TESTING, CHEMISTRY, DRUG LEVELS, HEMATOLOGY, IMMUNOLOGY TESTS, URINE CHEMISTRY, URINE TESTING, OB/GYN, MICROBIOLOGY TESTING, MOLECULAR AND STOOL STUDIES.

3. **Marking Test:** Mark the box to the left of the testing and keep within the boundary of the appropriated box or testing will be delayed to first clarify what testing is needed.

4. **Tube Code:** On the right hand side of the test box we indicate the appropriate specimen type. A key explaining the abbreviations is at the bottom of the page.

5 **Additional Prompts:** When appropriate complete any additional prompts. Examples are drug Level dosage, total urine volumes, patient height and weight with appropriate units, and antibiotic information.

6 **Unlisted Tests:** Use the blank space at the bottom right and provide a complete description of the ordered test. No abbreviations. Find test on our web page for correct name.

7 **Web Page:** Refer to our Laboratory Test Directory on web page **www.chihealth.com/lab-services** for instructions on proper handling of specimens.

8 **Specimen Labeling:** We require on all specimens permanent identifiers of ***Patient's Last Name, First Name, Date of Birth, Collection Date and Time, and Initials of Collector.***

9 **Call/Fax**: If lab results are to be called or faxed, mark appropriate box, name of fax recipient, and secure fax telephone number.

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Client Code: ****
Clinic Name:
Clinic Address:
City, State, Zip:
Phone:
Fax:

☐ Stat ☐ Call ☐ Fax
(Both name and number required)

Name:
Number:
MRN:
CSN:

PATIENT INFORMATION REQUIRED FOR TESTING

(Legal Name) Last	First	MI	DOB	SSN	☐ Male ☐ Female	Patient Phone Number

Patient ID	Physician #1 First & Last Name	Physician #2 First & Last Name	Date Collected	Time Collected	By

REQUIRED: Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below

ICD10	1.	2.	3.	4.

MUST Check One:
☐ **Bill to Office Account**
☐ **Skilled Care – Bill to Office Account**
☐ **Bill to Patient / Insurance**

When tests printed in red are ordered on Medicare patients they are likely to be denied by Medicare unless medical necessity is established. Consult guide for complete list of NCD/LCD tests and have patient sign ABN waiver, if appropriate.
ABN waiver signed and attached? ☐ **Yes** ☐ **No**

MUST complete **ALL** information below or attach demographic **AND** insurance sheet.

Responsible Party:	**Relationship to Policy Holder** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____	**Primary Insurance Name**	**Secondary Insurance Name**
		Address:	Address:
Name:		City, State, Zip:	City, State, Zip:
Address:		Policy Number:	Policy Number:
City, State, Zip:		Group Number:	Group Number:
Phone Number of Guarantor:		Group Name:	Group Name:

Test Code		Approved Panels	Tube
80048		BASIC METABOLIC PANEL	P
80053		COMP. MET PANEL	P
80051		ELECTROLYTE PANEL	P
80076		HEPATIC FUNCTION PANEL	P
80069		RENAL FUNCTION PANEL	P
80061		LIPID PANEL w/ D LDL REFLEX	P
LIPNO		LIPID PANEL w/o D LDL REFLEX	P
80074		ACUTE HEPATITIS PANEL	S
		Thyroid Testing	
84443		TSH 3RD GENERATION	S
84439		FREE T4	S
84436		T4 (TOT THYROXINE)	P
84481		FREE T3	S
84480		TOTAL T3	S
86376		TPO ANTIBODY	S
84432		THYROGLOBULIN ANTIBODY	S
		Chemistry	
82040		ALBUMIN	P
84075		ALK PHOSPHATASE	P
84460		ALT (SGPT)	P
82150		AMYLASE	P
84450		AST (SGOT)	P
82607		B12, VITAMIN	S
HCG		BETA HCG QUAL PREG SERUM	S
84702		BETA HCG QUANTITATIVE	P
82248		BILIRUBIN, DIRECT	P
82247		BILIRUBIN, TOTAL	P
BUN		BUN	P
CA 125		CA 125	S
CA 153		CA 15-3	S
CA 199		CA 19-9	S
CA 2729		CA 27-29	S
82310		CALCIUM	P
82378		CEA	S
PROBN		PRO BNP	P
82435		CHLORIDE	P
82465		CHOLESTEROL	P
82374		C02	P
		CORTISOL _____ AM _____ PM	S
82550		CPK	P
82565		CREATININE	P
CRP		CRP	P
CRPH		CRP, HIGH SENSITIVITY	P
		DRUG LEVELS	
AMIT		AMITRYPTYLINE/NORTRIP	R
80156		CARBAMAZEPINE (TEG)	P
80162		DIGOXIN (LANOXIN)	P
80178		LITHIUM	S
80182		NORTRIP (PAMELAR)	R

Test Code		Chemistry	Tube
83721		DIRECT LDL	P
82670		ESTRADIOL	S
82728		FERRITIN	S
82746		FOLIC ACID (FOLATE)	S
83001		FSH	S
82947		GLUCOSE RANDOM OR FASTING	P
	GLCH	GST GLUCOSE CHALLENGE 1 HR (50 GM) 1HR POST)	P
	GGT2	GEST GLUCOSE TOLERANCE 2 HR (75GM) (FAST, 1HR, 2HR)	P
	GGLU	GEST FLUCOSE TOLERANCE 3 HR (100GM) (FAST, 1HR, 2HR, 3HR, POST)	P
	GLUT	NON-GEST GLUCOSE TOLERANCE 2HR (75GM) (FAST, 2HR POST)	P
82977		GGT	P
83718		HDL	P
83036		HEMOGLOBIN A1C	L
HOMOC		HOMOCYSTEINE	P
83540		IRON	S
IIBC		IRON, IBC, & IRON SAT.	S
LEDFP		LEAD (FILTER PAPER)	
83655		LEAD (WHOLE BLOOD)	L
83002		LH	S
836900		LIPASE	P
83735		MAGNESIUM	P
84100		PHOSPHORUS	P
84132		POTASSIUM	P
84134		Pre-Albumin	P
84144		PROGESTERONE	S
84146		PROLACTIN	S
84165		PROTEIN ELECTROPHORESIS	S
84155		PROTEIN, TOTAL SERUM	S
84153		PSA (DIAGNOSTIC)	S
G0103		PSA (MEDICARE SCREENING)	S
PTHI		PTH (INT) w/ CALCIUM	S
84295		SODIUM	P
84402		TESTOSTERONE(FREE) Child	R
84403		TESTOSTERONE(TOTAL) Child	S
TESTFM		TESTOSTERONE(FREE)	S
TESTT		TESTOSTERONE(TOTAL)	S
84478		TRIGLYCERIDES	P
84550		URIC ACID	P
82306		VIT D. 25 HYDROXY	S
80185		PHENYTOIN (DILANTIN)	P
80188		PRIMIDONE (MYSOLINE)	R
80198		THEOPHYLLINE	R
80164		VALP. ACID (DEPAKENE)	P
80177		KEPPRA	R

Test Code		Hematology	Tube
85027		CBC NO DIFF	L
85025		CBC w/ DIFF	L
85610		PT w/ INR (MED ____________)	B
85730		PTT (MED ____________)	B
85045		RETICULOCYTE	L
SED		SEDRATE (ESR)	L
85018		HEMOGLOBIN	L
85014		HEMATOCRIT	L
85303		PROTEIN C (FUNCTIONAL)	B
85306		PROTEIN S (FUNCTIONAL)	B
85300		ANTI THROMBIN III (FUNCTIONAL)	B
		IMMUNOLOGY TESTS	
ANA		ANA (ANA SCREEN NO REFLEX)	S
HAB		HEPATITIS A ANTIBODY IgM	S
86706		HEP B SURF AB IMMUNITY	S
87340		HEP B SURF AG	S
HBC		HEPATITIS B CORE AB IgM	S
HEPBCT		HEPATITIS B CORE ANTIBODY TOTAL	S
HCAB		HEPATITIS C AB	S
MYCO		MYCOPLASMA IgM	S
86308		MONOSPOT	S
86431		RHEUM. FACTOR (Quant)	S
86762		RUBELLA IgG	S
SYPH		SYPHILIS SCREEN (Qual)	S
87389		HIV 1+2 Ag/Ab	S
		URINE CHEMISTRY	
		24-HR URINE	
		TOTAL VOLUME __________ mL HT ______ ft/cm WT ______ lbs/kg "FOR CREATININE CLEARANCE NEED HT, WT AND SERUM FOR CREATININE OR CREATININE RESULT FROM LAST 7 DAYS.	
82575		CREAT/CLEAR 24 HR	
82570		CREAT, 24 HR URINE	
UPROT		PROTEIN 24 HR URINE	
		RANDOM URINE TESTING	
HCG URINE		BETA HcG QUALITATIVE URINE	
CREATU		CREAT URINE	
83835		METANEPHRINES, URINE	
MICROLAB		MICROALBUMIN (INCLUDES CREAT)	
PROTU		PROTEIN, URINE	
PROTCR		PROTEIN/CREATININE RATIO	
		URINE TESTING	
UAI		UA w/ MICROSCOPIC IF IND	
UAM		UA w/ MICROSCOPIC	
UAC		UA w/ CULTURE IF IND	
UAMC		UA w/ MICROSCOPIC, CULTURE IF IND	

Test Code		OB/GYN	Tube
80055		OBSTETRIC PANEL IP	1S 2L
80081		OBSTETRIC PANEL w/ HIV IP	1S 2L
ABORH		ABO GROUP AND RH	L
86850		ANTIBODY SCREEN	L
86765		RUBEOLA IgG	S
CF		CYSTIC FIBROSIS (need info sheet)	L
QUAD		QUAD SCREEN (need info sheet)	S
		MICROBIOLOGY	
AFBC		AFB CULT, SITE ____________	
CBLD		BLOOD CULTURE ____________	
BFC		BODY FLUID CULT, SITE ________	
FUNG		FUNGUS CULT, SITE ________	
87101		FUNGAL DERM CULT hair, nails, skin	
GENC		GENITAL CULT	
MRSA		MRSA SCREEN, SITE ________	
STREP		STREP A CULT	
RTC		ROUTINE CULT (WOUND) SITE ____	
ANAC		ANAEROBIC CULT	
SPTC		SPUTUM CULT	
TISSC		TISSUE CULT SITE ____________	
URC		URINE CULT	
VGBC		VAG. GRP B STREP CULT	
AFF		VAG. DNA PROBE (AFFIRM)	
		MOLECULAR	
		INFLUENZA A/B & RSV BY PCR	
		COV/FLU/RSV PCR	
		STREP A PCR, THROAT	
87493		C. diff AG/Tox Assay	
87491		CHLAMYDIA PCR	
87591		GONORRHEA PCR	
CTNG		GC/CHLAMYDIA PCR	
CMV PCR		CMV PCR	
HCRN		HEPATITIS C VIRAL LOAD	
87536		HIV VIRAL LOAD	
87529		HSV/PCR	
MEN		MENINGITIS/ENCEPHALITIS BY PCR	
BORDPCR		B. PERTUSSIS BY PCR	
COVID19		COVID-19 PCR	
VZVPCR		VZV PCR	
		STOOL STUDIES	
FECW		FECAL LEUKOCYTES	
STOOL		FECAL (STOOL) CULT	
GIA/CR		GIARDIA/CRYPTO SCREEN	
		GI Profile PCR	
		H PYLORI FECAL ANTIGEN	
82270		OCCULT BLOOD	
87177		OVA & PARASITE	
87425		ROTAVIRUS ANTIGEN	
		ADDITIONAL TESTS	

PROCESSORS ONLY: IF DATE OR TIME IS NOT PROVIDED THEN ENTER "NOT PROVIDED"	Dose Information Required	Time of Last Dose
	Medication Name	Date of Last Dose

TUBE KEY: S=SST (SERUM) P=PST (PLASMA) L=LAVENDER B=BLUE R=RED IF NO TUBE TYPE LISTED CONSULT CATALOG

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