

**BLOOD LEAD ANALYSIS
TEST REQUEST FORM**

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME				FIRST NAME				MI		COLLECTION DATE		TIME		REPORT		STAT					
/ /										___ AM		<input type="checkbox"/> CALL		<input type="checkbox"/>							
DOB		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PT. ID# / ADDITIONAL INFO						PROVIDER: _____ (First, Last, MI)											
SSN				BILL TO: <input type="checkbox"/> OFFICE/CLIENT <input type="checkbox"/> PATIENT INSURANCE						Account Number											
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED														Account Name							
GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)																					
ADDRESS				CITY				STATE		ZIP		Street Address									
PRIMARY INSURANCE <input type="checkbox"/> MEDICARE IN-PATIENT <input type="checkbox"/> MEDICARE OUT-PATIENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE																					
POLICY ID#						GROUP ID#						City		State		Zip Code					
INSURANCE COMPANY								PHONE NUMBER						Phone				Fax			
INSURANCE COMPANY ADDRESS				CITY				STATE		ZIP		SECONDARY / TERTIARY INS - ATTACH INFORMATION									
EFFECTIVE DATE / /						<input type="checkbox"/> ABN ATTACHED <input type="checkbox"/> PRIOR AUTHORIZATION ATTACHED															
DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)																					
ICD-10 #1				ICD-10 #2				ICD-10 #3				NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. FOR MORE INFORMATION SEE reglab.org/billingcompliance/									

EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER

LEAD
SOURCE: CAPILLARY
VENOUS

PLEASE PROVIDE PATIENT ADDRESS

MANDATORY FOR TESTING

Address: _____

City: _____

State: _____

Zip: _____

COMMENTS/ADDITIONAL INFORMATION:



Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/ testing supplies and log-on information may be obtained by calling Client Services
Toll Free 800-334-0459
Phone 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call
client services Toll Free 800-334-0459
Phone 402-559-6420

If shipping specimens address to:
Regional Pathology Services
University of Nebraska Medical Center
668 S 41st St., MSB 3500
Omaha, NE 68105-1180

Transport Instructions: Specimen Handling/Shipping

To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?

Contact client services at 800-334-0459