UNILAB

INFERTILITYLAB.COM TEST REQUISITION

REQUIRED INFORMATION

PATIENT NAME		SEX	D.O.B.	COLLECTION DATE	COLLECTION TIME	FASTING	STAT
		☐ M	/ /	/ /	: AM ☐	☐ Yes	☐ Yes
LAST	FIRST	☐ F			PM ☐	☐ No	☐ No

BILL TO   ☐ CLIENT   ☐ PATIENT   ☐ MEDICARE   ☐ INSURANCE

☐ CREDIT CARD #_____ ☐ MC ☐ VISA ☐ AE   NAME ON CARD:_____ EXP. DATE_____

PATIENT INFORMATION

PATIENT ADDRESS	MEDICARE #	PHONE #
CITY STATE ZIP	DIAGNOSIS / ICD10 CODE	

PATIENT/RESPONSIBLE PARTY SIGNATURE; I have read and understand the Advance Beneficiary Notice and the Unilab Billing Policy. I agree to make payment in full when asked to do so. I authorize the release of any medical information necessary to process this or related claims and authorize payment of medical benefits to Unilab of Dade. Please read reverse side.

INSURANCE NAME

INSURANCE ADDRESS

X_____
Patient or Responsible Party   Date

POLICY NUMBER   GROUP NUMBER

NOTES

PANELS

FDA Female Donor (2 SST, 5 Lavender, 1 BD Urine ProbeTec.) GC/Chlamydia By DNA Amp., Hepatitis B Core Total Ab, Hepatitis B Surface Ag, Hepatitis C Ab, HIV-I/II/O Ab Screen, MPX:HBV/HCV/HIV, RPR Qual., WNV by PCR

FDA Male Donor (2 SST, 5 Lavender, 1 BD Urine ProbeTec.) GC/Chlamydia By DNA Amp., Hepatitis B Core Total Ab. Hepatitis B Surface Ag, Hepatitis C Ab, HIV-I/II/O Ab Screen, MPX:HBV/HCV/HIV, RPR Qual., HTLV I/II, CMV Total Ab, West Nile Virus by PCR

FERTILITY TESTS

Reproductive STATS		Male Infertility		Testosterone	(SST)	General Assays	
B-HCG quant.	(SST)	Male Reproductive Hlth Panel	(Semen)	TSH	(SST)	CBC w/ Diff & Platelets	(LAV)
Estradiol	(SST)	S.C.F.A.	(FRZ Semen)	Vitamin D, 25 – Hydroxy.	(SST)	Comprehensive Metabolic Profile 12	(SST)
FSH	(SST)	Sperm DNA Decondensation – SDD/SDAD	(Semen)	**Autoimmunity/Immunology**		CRP-hs	(SST)
LH	(SST)	Y Chromosome Microdeletion	(LAV)	ANA Screen	(SST)	Ferritin	(SST)
Progesterone	(SST)	**Endocrinology**		Anti-Ovarian Ab	(SST)	Folates	(SST)
FDA Donor Testing		17-OH Progesterone	(SST)	Anti-Sperm Ab (serum)	(RED)	Glucose ( ) Fasting ( ) Non-Fasting	(SST)
CMV Total Ab reflex to IgM	(LAV) (SST)	ACTH	(LAV)	Natural Killer Cells Activation Assay	(GRN)	G.G.T.	(SST)
T. cruzi (Chagas)	(SST)	Anti-Mullerian Hormone (AMH)	(SST)	Thyroglobulin Ab (TG)	(SST)	Hemoglobin A1c	(LAV)
GC/Chlamydia by DNA Amp	(UR/SWAB)	Aldosterone	(SST)	Thyroid Peroxidase Ab (TPO)	(SST)	Hepatic Function Panel	(SST)
Hepatitis B Core Total Ab	(SST)	C-Peptide	(SST)	**Antiphospholipids**		Homocysteine	(SST)
Hepatitis B Surface Ag	(SST)	Cortisol ( ) AM ( ) PM	(SST)	Anticardiolipin Ab (IgG, IgM, IgA)	(SST)	Iron/TIBC	(SST)
Hepatitis C Ab	(SST)	DHEA - S	(SST)	Antiphospholipid Comprehensive Ab Panel	(SST)	Lipid Panel	(SST)
MPX PCR: HBV/HCV/HIV	(LAVx2)	Estrogen	(SST)	Beta-2 Glycoprotein I Ab (IgA, IgG, IgM)	(SST)	PAP Liquid w/ HPV Reflex	Call Lab
HIV I/II/O - Ab Screen	(SST)	Free & Bioavailable Testosterone by Calculation	(SST)	**Coagulation**		Prostate Specific Antigen (PSA)	(SST)
HTLV I/II	(SST)	Growth Hormone	(SST)	Antithrombin III Activity	(B)	Rubella Ab. IgG	(SST)
RPR Qual.	(SST)	IGF Binding Protein-1 (IGFBP-1)	(SST)	Antithrombin III Ag	(B)	Urinalysis	(UR)
West Nile Virus PCR	(LAVx2)	IGF-1	(SST)	Factor V Leiden DNA Mutation	(L)	Varicella Z. IgG	(SST)
Additional Donor Tests		Inhibin B ( ) Female ( ) Male	(SST)	Factor VIII Activity	(B)	**Cultures**	
ABO+Rh	(LAV)	Insulin ( ) Fasting ( ) Non-Fasting	(SST)	Lupus Anticoagulant Profile	(LAV)	Urine Culture	
Antibody Screen	(LAV)	PTH Intact with Calcium	(FRZ Serum)	Plasminogen Act Inhibitor-1 (PAI-1)	(B)	Bacterial Culture	(SWAB)
Blood Chromosome Analysis	(GRN)	Prolactin	(SST)	Protein C Activity	(B)	Source:_____	
Drug Screen (10)	(UR)	SHBG – Sex Hormone Binding Globulin	(SST)	Protein S Activity	(B)	**Additional Tests**	
Nicotine Urine Drug Screen	(UR)	T-3 Free	(SST)	Prothrombin (Factor II) Mutation	(L)		
Cystic Fibrosis (32 mutations)	(L/Y)	T-3 Total	(SST)	PT-PTT	(B)		
Myco/Urea Culture	Call Lab	T-3 Uptake	(SST)	PTT (Partial Thromboplastin Time)	(B)		
Zika IgM	(SST)	T-4 Free	(SST)				
Zika PCR	(LAV)	T-4 Total	(SST)				

A. **Notifier:**

B. **Patient Name:**   **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.**   I want the   **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 03/2020)   Form Approved OMB No. 0938-0566

Worry Free Billing

Lab costs and their bills are worry-free with Unilab. Not only is Unilab a Medicare provider, but we also accept any PPO and POS insurance plans. If it turns out your insurance company does not cover a specific test, Unilab will reduce the original cost of the test to our patient friendly prices. Unilab does not participate with any HMO insurance plans.

Will Patients Receive a Bill From Unilab?

There are **four** instances in which a patient would receive a bill from Unilab:

1. If Unilab learns that payment for services was sent directly to the patient and not forwarded to our billing department as requested above.
2. If the patient does not have Medical Insurance or opts for services at the Cash Price
3. If Unilab has filed claims with the patient's insurance company and the patient has NOT met the patient contribution requirements (i.e. deductibles or co-pays for laboratory services)
4. If your insurance company denies any of the charges that are submitted from Unilab. Examples: no coverage at time of service, not covered diagnostic codes, bad or missing information

For any billing or other payment questions, please contact our office at 1.877.522.5678 and simply select "Billing" when prompted.