SCANTIBODIES Clinical Laboratory
Medical Director: Frank Wesley Hall, M.D.
9236 Abraham Way • Santee, CA 92071
Phone: (800) 365-5166 • (866) 249-1212
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FACILITY NAME AND ADDRESS

PHONE:

PATIENT NAME (LAST) (FIRST) (M.I.)

PLEASE PRINT

PATIENT ADDRESS

CITY STATE ZIP

SSN PHONE

BIRTHDATE SEX MRN#

REFERRING PHYSICIAN N.P.I.

ICD-9 CODE

1	2	3	4

☐ PLEASE FAX RESULTS TO: (   )

COLLECTION DATE ______ — ______ — ______ TIME ______________
Month Day Year

☐ Serum ☐ Plasma ☐ Whole Blood ☐ Other

☐ Fasting (Hours) ______________ ☐ Phlebotomist's Initials ____________

PRIMARY INSURANCE

☐ MEDICARE ☐ MEDICAID/MED-CAL ☐ OTHER ☐ CLIENT

MEDICARE/MEDICAID #

INSURED ID # GROUP #

INSURANCE COMPANY

ADDRESS

CITY STATE ZIP

SECONDARY INSURANCE

☐ MEDICARE ☐ MEDICAID/MED-CAL ☐ OTHER

MEDICARE/MEDICAID #

INSURED ID # GROUP #

INSURANCE COMPANY

ADDRESS

CITY STATE ZIP

When ordering tests for Medicare and Medicaid patients, please select only those tests which are medically necessary for the diagnosis or treatment of the patient. Medicare DOES NOT pay for routine screening.

TEST CODE	TEST	MIN. REQUIREMENTS	CPT CODE
( ) 11100	CAP PTH ASSAY	1ML FRZ EDTA PLASMA	83970
( ) 11000	TOTAL PTH ASSAY	1ML FRZ EDTA PLASMA	83970
( ) 1000	PTH ACCURATIO (SCL COMP. PROFILE) TOTAL PTH ASSAY CAP PTH ASSAY CIP VALUE CAP/CIP RATIO	2ML FRZ EDTA PLASMA	83970 X2

SAMPLE

BY SIGNING BELOW YOU AUTHORIZE SCL TO PERFORM INDICATED TEST.

AUTHORIZED SIGNATURE DATE

FOR LABORATORY USE:

☐ ROOM TEMPERATURE ☐ REFRIGERATED ☐ FROZEN RECEIVED BY______________________ DATE/TIME ______________

WHITE COPY: LAB YELLOW COPY: BILLING PINK COPY: KEEP FOR YOUR OWN RECORDS

621-B