MHS LABS

Tel 800.443.2035 | Fax 412.373.0539

Date Collected	Time Collected	Was patient fasting? ☐ YES ☐ NO	VNP Site

PATIENT INFORMATION — REQUIRED

First Name | Last Name | ☐ Male ☐ Female

Date of Birth | Social Security Number

Street Address

City | State | Zip

Home Phone | E-mail

FACILITY INFORMATION — REQUIRED

Room Number

PROVIDER SIGNATURE & MEDICAL NECESSITY — REQUIRED

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

I certify that (i) this test / (genetic test when applicable) is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and MHS Labs' Patient Informed Consent. I agree to provide MHS Labs, or its designee, any and all additional information reasonably required for this testing to be performed and billed.

SIGNATURE REQUIRED

Physician Name | NPI:

Signature

ICD 10 DX CODES — REQUIRED

☐ BASIC STOOL CULTURE BY PCR - P20001

Bacterial:

- ☐ Campylobacter (jejuni, coli, and upsaliensis)
- ☐ Clostridium difficile (toxin A/B)
- ☐ Plesiomonas shigelloides
- ☐ Salmonella
- ☐ Yersinia enterocolitica
- ☐ Vibrio (parahaemolyticus, vulnificus, and cholerae)
- ☐ Vibrio cholerae

☐ ***Parasites:***

- ☐ Cryptosporidium
- ☐ Cyclospora cayetanensis
- ☐ Entamoeba histolytica
- ☐ Giardia lamblia

Diarrheagenic E. Coli /Shigella

- ☐ Enteroaggregative E. coli (EAEC)
- ☐ Enteropathogenic E. coli (EPEC)
- ☐ Enterotoxigenic E. coli (ETEC) lt/st
- ☐ Shiga-like toxin-producing E. coli (STEC) stx1/stx2
- ☐ E. coli 0157
- ☐ Shigella/Enteroinvasive E. coli (EIEC)

Viruses:

- ☐ Adenovirus F40/41
- ☐ Astrovirus
- ☐ Norovirus GI/GII
- ☐ Rotavirus A
- ☐ Sapovirus (I, II, IV, and V)

☐ C. Difficile Toxin A/B + GDH Anitgen, EIA - M10777

- ☐ Clostridium difficile (toxin A/B)

☐

☐

PAYMENT INFORMATION

☐ **INSURANCE** ☐ **CLIENT BILL** ☐ **PATIENT (PRE-PAY)**

Insurance Name

Policy ID Number | **Group Number**

Policy Holder Name | Date of Birth

Policy Holder Social Security Number

Relationship to Patient | Phone Number

Policy Holder Address

City | State | Zip

Secondary Insurance

Policy ID Number | Group Number

Pre-Payment ☐ CASH ☐ CHECK ☐ CREDIT CARD (ONLINE)

Amount Collected $ | Send Cash or Check in Money Bag Only

I authorize MHS to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay MHS Labs for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance. **SIGNATURE REQUIRED**

Patient/Guarantor | **Date**

Signature

SPECIMEN INFORMATION — REQUIRED

Urogenital ☐ Urine | Other:

☐ Clean Catch ☐ Random ☐

☐ Straight Cath ☐ Indwelling Cath

☐ Other:

SAMPLE LIST OF DIAGNOSIS CODES

The ICD-10 codes provided are for informational purposes only.

Correct ICD-10 coding is the sole responsibility of the ordering provider.

ADDITIONAL TESTS/PROFILES

SEND COPY OF REPORT TO

Physician | Fax