

OFFICE USE ONLY

Round Trip Mileage: _____
Phlebotomist: _____
Tracking Number: _____



224 N. Highway 67 Suite 252
Florissant, MO 63031
PH: 314-942-3272/ FAX: 314-584-2205

Inaccurate or Incomplete information may delay results and/or collection

Patient's Legal Name _____ Sex _____ DOB _____

Patient's Address _____

Phone _____ Collection Time _____ Collection Date _____

Standing order Yes/No Frequency _____ Fasting _____

Physician's Name _____ NPI _____ FAX _____

Ordering Provider's Signature _____ Phone _____

Physician's signature indicates agreement of below ordered tests collected by My Blooming Health CLIA waved lab and partnered with a regulated lab for specimen processing.

Primary Billing Party

Insurance Carrier _____

ID# _____

Group# _____

Insurance address _____

Name of Insured Person _____

Relationship to patient _____

Collection Site: HOME NURSING HOME Other (Name of Facility): _____ Homebound: Yes/No _____

Secondary Billing Party

Insurance Carrier _____

ID# _____

Group# _____

Insurance address _____

Name of Insured Person _____

Relationship to patient _____

Test Information: STAT -if Stat, drop off at CHNE FREEZE REFRIGERATE

| | | | |
|---|--|--|--|
| Diagnosis/ICD - 10 Codes (icd10data.com/convert) | | | |
|---|--|--|--|

| Gel Tube/SST | Gel Tube/SST | Lavender | Blue | Urine |
|------------------------|----------------------|------------------------|---|-------------------|
| Acute Hep Panel | LDH | Ammonia (lab specific) | PT/INR | Urinalysis |
| Albumin | Magnesium | BNP-frozen plasma | PT and PTT | U/A with Micro |
| Amylase | Phosphorus | CBC | PTT | Urine C & S |
| BMP | Potassium | CBC with Diff | Gray | Stool |
| B12 and Folate | PSA, serum | CBC with Diff & Plt | Glucose, Plasma | Stool Culture |
| C-Reactive Protein | Renal Function Panel | Folate | Glucose Tolerance test | C. Diff |
| Cholesterol, Total | Sodium | Hematocrit | Mint Green, Ice Water 60min (CHNE) | Ova and Parasites |
| CMP | Testosterone | Hemoglobin | Ammonia | FOB |
| Electrolyte Panel | TSH | Hgb A1C | Therapeutic -Red Top | Other |
| Ferritin | T4 | | Digoxin | |
| Glucose, Serum | T4 Free | Platelet count | Dilantin | |
| Hepatic Function | T3 | Parathyroid Hormone | Lithium | |
| Hep A antibody, IgM | Reverse T3 | Sed Rate, Westergren | Phenobarbital | |
| Hep B Surface Antibody | Uric Acid | WBC | Tegretol | |
| Hep B Surface Antigen | Vitamin B 12 | Folate | Vancomycin | |
| HIV | Vitamin D | | | |
| Lipid Panel | | | | |

I authorize the release of medical information necessary to process this claim and request payment of benefits to the party who accepts assignment. I permit the copy of this authorization to be used in place of the original. I understand that Medicare is likely to deny payment for certain procedures. I agree to be personally responsible for payment of laboratory services if Medicare does not provide payment. I authorize MBHM to perform service(s) and share results with my ordering provider.
Sign: _____ Date _____