

CLINICAL HISTORY FORM



**Michigan Medicine
Laboratories (MLabs)**

mlabs.umich.edu
800.862.7284
FAX: 734.936.0755

FORM MUST BE ACCOMPANIED BY A SEPARATE REQUISITION

SPECIMEN SHIPMENTS ONLY:

N-LNC Specimen Processing, 2800 Plymouth Rd,
Bldg 35, Ann Arbor, MI 48109-2800

Client Name: _____

Patient Reg or MRN: _____

Patient Name: Last First MI

Birthdate: Gender: OM OF

Ordering Provider: Last First NPI#

COLLECTION DATE Indicate the type of patient encounter on the date that the specimen was removed from the patient.

Inpatient: Admission Date _____ Discharge Date _____

Outpatient: Visit/Procedure Date _____

Not a registered hospital inpatient or outpatient: Visit/Procedure Date _____

Bill To: Client/Referring Institution Patient/Insurance
Medicare No Yes (include copy of patient's Medicare card)

If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client.

ICD-10 CODES

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

OTHER INFORMATION (Complete only if patient's insurance is NOT traditional Medicare)

Primary indication(s) for ordering of this test?

How will the result of this test influence the diagnosis or the patient's treatment plan?

If this test is for genetic purposes, does the patient display clinical features of the inherited mutation in question? If so, what are those features?

For genetic testing, is there a family history of this disease? If yes, please list all affected family members and relationship to patient (i.e. mother, father, sibling, maternal grandmother, etc.)

INSTRUCTIONS (REQUIRED DOCUMENTATION)*

Please attach/include:

- Pathology Report Consent for Genetic Testing Family Genetic Pedigree Chart Copy of Insurance Card
 Relevant Clinical Notes Genetics Counselor Note Other _____

* The Centers for Medicare/Medicaid Services requires that the performing laboratory bill CMS directly for certain services, rather than billing the facility; even when your facility has a client billing relationship with your reference laboratory. Refer to the patient's insurance information to determine if the patient's PRIMARY insurance is traditional Medicare.

Please fill out the above information and sign. Fax this completed form to MLabs at 734.647.0141

For more information on how to complete this form, please call us at 800.862.7284