



# Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

Collection Date: \_\_\_\_\_ Phlebotomist Initials: \_\_\_\_\_  Physician Office  Other  Draw Site: \_\_\_\_\_

## TESTS REQUESTED

(VDS-125)OVA1plus OVA1\*plus is a reflex test in which OVA1\* is performed and then reflexes to OVERA\* if the OVA1\* result is in the intermediate range. This testing assesses the likelihood that an ovarian mass is malignant prior to planned surgery.

(GCP-100) Germ Cell Panel (Includes: AFP, bHCG, LDH)

### Germ Cell Tests:

- AFP (GCP-110)
- bHCG (GCP-120)
- LDH (GCP-130)

### Mucinous Tests:

- CA19-9 (MCP-120)
- CEA (MCP-110)

(MCP-100) Mucinous Panel (Includes: CA19-9, CEA)

## PROVIDER INFORMATION

Physician name(s): \_\_\_\_\_ NPI#: \_\_\_\_\_

Name/Account #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Fax copy to Name: \_\_\_\_\_

Fax copy to Number: \_\_\_\_\_

## PATIENT INFORMATION & AUTHORIZATION

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB (mm/dd/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone number: \_\_\_\_\_ MRN: \_\_\_\_\_

Email address: \_\_\_\_\_

Ethnicity (Check all that apply):

- Caucasian  Ashkenazi Jewish  Sephardic Jewish  Asian
- Hispanic  Native American  African American
- Other: \_\_\_\_\_

I authorize ASPIRA LABS to release medical information related to services provided herein and authorize payment directly to ASPIRA LABS. More information is available at <https://aspirawh.com/licensure-and-legal/> I agree to assume responsibility for payment of charges that are not covered by my healthcare insurer.

\*\*Patient's Signature: \_\_\_\_\_

\*\*patients signature required for verification of benefits

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICIAN SIGNATURE

Physician's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

## CLINICAL INFORMATION & DIAGNOSIS CODES

Menopausal Status:  Pre-Menopausal  Post-Menopausal

Ultrasound Results:  Low Risk  High Risk  Not Definitive

Date of last menstrual period: \_\_\_\_\_ Size of mass (longest dimension): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**DIAGNOSIS CODES | ICD-10 Codes (check all that apply):** \*This is provided for informational purposes only and is not a guarantee of coverage. It is the provider's responsibility to determine the appropriate codes.

- N83.201 Unspecified ovarian cyst, right side\*
- N83.202 Unspecified ovarian cyst, left side\*
- N83.209 Unspecified ovarian cyst, unspecified side\*
- R19.00 Intra-abdominal and pelvic swelling, mass and lump, unspecified site\*
- R19.03 Right lower quadrant abdominal swelling, mass and lump\*
- R19.04 Left lower quadrant abdominal swelling, mass and lump\*
- R19.05 Periumbilical swelling, mass and lump\*
- R19.09 Other intra-abdominal pelvic swelling, mass and lump\*

Other ICD-10 Codes: \_\_\_\_\_

Does the patient:	No	Yes	If YES:
Have pain in the abdomen or pelvis?			How many days per month? <input type="checkbox"/> 0-5 days <input type="checkbox"/> 6-12 days <input type="checkbox"/> >12 days For how long: <input type="checkbox"/> <1 month <input type="checkbox"/> 1-6 months <input type="checkbox"/> 7-12months <input type="checkbox"/> >12 months
Feel full quickly or unable to eat normally?			How many days per month? <input type="checkbox"/> 0-5 days <input type="checkbox"/> 6-12 days <input type="checkbox"/> >12 days For how long: <input type="checkbox"/> <1 month <input type="checkbox"/> 1-6 months <input type="checkbox"/> 7-12months <input type="checkbox"/> >12 months
Experience abdominal bloating or an increased abdominal size?			How many days per month? <input type="checkbox"/> 0-5 days <input type="checkbox"/> 6-12 days <input type="checkbox"/> >12 days For how long: <input type="checkbox"/> <1 month <input type="checkbox"/> 1-6 months <input type="checkbox"/> 7-12months <input type="checkbox"/> >12 months

## BILLING INFORMATION

**Bill the Following (required):**  Private Insurance  Medicare\*  Patient Self-Pay  Medicaid  Ordering Facility (Client Bill)

\*By ordering this test for your Medicare patient, you are certifying that the patient has met the requirements for use i.e. has an ovarian mass, has surgery planned and is over 18 years of age.

**Insurance Information:** Attach a copy of front and back of patient insurance card and complete.

Primary insurance carrier: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Secondary insurance carrier: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Name of insured: Last: \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_ Relationship to insured:  
 Self  Spouse  Dependent  Other
