2938

REFERENCE LABORATORY HIV TESTING REQUISITION

Date of Request _____ **Visit Number:** _____

Chart#: _____ **Location:** _____

Patient Name: _____

Date of Birth: _____

BASSETT HEALTHCARE NETWORK

Quest Diagnostics
HIV Testing Form
#2938 (flab\.doc) rev. 1/10,7/19/10, 1/3/2011, 6/3/11;10/13/11,1/16/2012,7/19/12,10/1/12,1/7/13,7/1/13, 1/6/14,10/6/14,8/17/15,4/19/19,2/10/22,3/14/22,2/16/26

Initials	Date	Time

Patient's Address	Street Address:		
	City:	State:	Zip Code:

Insured's Name (if different from patient) Relationship to Patient ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Primary Insurance Name and Plan (if applicable)	Employer/Group Name

Policy ID Number	Group / Plan / Book#	Cat.#

Medicaid ID#	(OR)	ADAP PLUS ID#

(√) Referring Provider Information

	Last Name, First Name	NPI#	NYS License #	Medicaid#
☐	HYMAN, CHARLES	1629062104	160045	02047712
☐	SENTOCHNIK, DEBORAH	1891751483	160173	02092359
☐				

Diagnosis Code(s) or Descriptive Diagnosis _____

(√) Testing Required

***Providers: Compliance is mandatory and regulated – see reverse. Quest Diagnostics Phone – 866-697-8378/Fax – 703-802-7131

Unit Code – Performing Lab	*EPIC Code*	*Test Name*
□ 91691 – Quest Diagnostics	LAB3789	HIV-1 RNA Quant, Real-Time PCR w/Reflex to Genotype (RTI, PI, Integrase)
□ 40085 – Quest Diagnositcs	LAB3788	HIV-1 RNA Quantitative, Real-Time PCR, Plasma
□ V3200–Monogram Biosciences	LAB101011	PhenoSense (Phenotype) - **MUST** use Monogram Requisition
□ V7000/V7100–Monogram Biosciences	LAB101011	PhenoSenseGT (Phentotype/Genotype) – **MUST** use Monogram Requisition
□ E3100–Monogram Biosciences	LAB101011	Trofile Co-Receptor Tropism Assay – **MUST** use Monogram Requisition
□ E3600–Monogram Biosciences	LAB101011	Trofile **DNA** Co-Receptor Tropism Assay – **MUST** use Monogram Requisition
□ R6000- Monogram Biosciences	LAB101011	GenoSure Archive DNA Sequencing PR-RT,IN- **MUST** use Monogram Requisition
□ R6000+E3600- Monogram Biosciences	LAB101011	GenoSure Archive Plus Trofile DNA- **MUST** use Monogram Requisition

New York Regulations require an authorized signature (submitting provider or designee).

X _____
Authorized Signature (submitting physician or designee)

_____ _____
Print Name and Title Date and Time

REQUISITIONS\Lab

PROVIDERS: Compliance is mandatory and regulated. For the laboratory to bill properly and receive payment, you must provide the specific ICD-10 codes for each outpatient test ordered. Additionally, only tests that are medically necessary for the indicated diagnosis or treatment should be ordered, with supporting documentation in the medical record. For tests included in each panel and reflexive testing, please refer to the below. Under current Medicare regulations, when certain laboratory tests (indicated by an *) are ordered, and the diagnosis is not listed in the Local Coverage Determination or National Coverage Determination for that test, payment may be denied. In these cases Medicare requires an Advance Beneficiary Notice (waiver of liability) be signed to allow the hospital to bill the patient. The ABN box on the requisition MUST be checked when an ABN is obtained.

☐ **Patient has signed ABN Waiver (ABN)** ☐ **Patient refused to sign ABN Waiver (ABNR)** ☐ **ABN not required**

Informed Consent Forms are available through the Bassett warehouse or from the following link: www.health.state.ny.us/forms/doh-2556.pdf