OMNIHEALTH DIAGNOSTICS

OmniHealth Diagnostics
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CLIA# 45D2089485 | Lab Director: Akhtar Afshan Ali
www.OmniHealthDX.com

CLINICAL TESTING

PATIENT - PLEASE PRINT LEGIBLY — REQUIRED

First Name | **Last Name**

Date of Birth | **Sex** ☐ Male ☐ Female | **Ethnicity** ☐ African American ☐ Asian ☐ Caucasian ☐ Jewish (Ashkenazi) ☐ Hispanic ☐ Portugese ☐ Other:_____

Street Address | **Apt/Suite #**

City | **State** | **Postal Code**

ORDERING PHYSICIAN — REQUIRED

Office/Practice/Institution Name

Physician Name(s)

Street Address | **Apt/Suite #**

City | **State** | **Postal Code**

SPECIMEN INFORMATION — REQUIRED

Specimen Type | **Date of Collection** | **Time of Collection** : ☐ AM ☐ PM | **Collectors Initials**

Diagnosis (ICD-10) Codes

PATIENT INSURANCE — REQUIRED: ATTACH PATIENTS FACESHEET & COPY OF INSURANCE CARD

☐ **Private** ☐ **Self Pay** ☐ **Workers Comp** ☐ **Medicare** ☐ **Medicaid**

Insurance Company | **Policy Number**

TEST REQUESTED — SELECT ONE (REQUIRED)

COMMON PANELS

	TUBE	CPT
☐ Basic Metabolic	SST	80048
☐ Comprehensive Metabolic	SST	80053
☐ Electrolytes	SST	80051
☐ Hepatic Function	SST	80076
☐ Lipid	SST	80061
☐ Renal Function	SST	80069
☐ Iron Panel	SST	83540; 83550

HEMATOLOGY

	TUBE	CPT
☐ CBC w/Auto Diff	LAV	85027
☐ Westergren Estimated Sedimentation Rate	LAV	85651

COAGULATION

	TUBE	CPT
☐ PT w/INR	BLUE	85610
☐ PTT	BLUE	85730

URINALYSIS

	TUBE	CPT
☐ Urinalysis w/o Microscopic	URINE	81003
☐ Urinalysis w/ Microscopic	URINE	81001

CHEMISTRY

	TUBE	CPT
☐ Albumin	SST	82040
☐ ALP	SST	84075
☐ ALT	SST	84460
☐ AST	SST	84450
☐ Bilirubin (Direct)	SST	82248
☐ Bilirubin (Total)	SST	82247
☐ BUN	SST	84520
☐ Calcium	SST	82310
☐ Chloride	SST	82435
☐ Cholesterol	SST	82465
☐ CO2	SST	82374
☐ Cortisol	SST	82533
☐ Creatine Kinase	SST	82550
☐ Creatinine	SST	82565
☐ CRPhs	SST	86141
☐ DHEA-s	SST	82627
☐ Estradiol	SST	82670
☐ Ferritin	SST	82728
☐ Folate	SST	82746
☐ Free T3	SST	84481
☐ Free T4	SST	84439
☐ FSH	SST	83001
☐ Glucose	SST	82947
☐ HDL Cholesterol	SST	83718

CHEMISTRY

	TUBE	CPT
☐ HDL Cholesterol	SST	83718
☐ HgbA1c	LAV	80069
☐ Insulin	SST	83525
☐ iPTH	LAV	83970
☐ Iron	SST	83540
☐ LH	SST	83002
☐ Magnesium	SST	83735
☐ Phosphorus	SST	84100
☐ Potassium	SST	84132
☐ Prolactin	SST	84146
☐ PSA	SST	84153
☐ SHBG	SST	84270
☐ Sodium	SST	84295
☐ T3	SST	84480
☐ T4	SST	84436
☐ Testosterone	SST	84403
☐ TIBC	SST	83550
☐ Total Protein	SST	84155
☐ Triglyceride	SST	84478
☐ TSH	SST	84443
☐ Uric Acid	SST	84550
☐ Vitamin B12	SST	82607
☐ Vitamin D (25 OH)	SST	82306

PHYSICIAN CONSENT & MEDICAL NECESSITY FOR TESTING — REQUIRED

I authorize **OmniHealth Diagnostics** and its affiliated labs to perform testing as directed by this test requisition form. I understand and hereby acknowledge that: When ordering test for which Medicare or Medicaid reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis of the patient. Components may be billed separately per carrier policy. NOTE: The Office of Inspector General (OIG) takes the position that a physician who orders medically unnecessary test(s) for which Medicare reimbursement is claimed, maybe subject to civil penalties.

Physician Signature:_____ **Date:** _____

PATIENT ACKNOWLEDGEMENT & CONSENT — REQUIRED

I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own and has not been adulterated in any manner. I certify that the information provided on this phone and on the specimen is accurate. I further authorize the laboratory to release the result of this testing to the ordering facility and/or my insurance company. I authorize my insurance company to pay in mail directly to **OmniHealth Diagnostics** and it's affiliated laboratories all benefits for payment of services rendered. I also authorize **OmniHealth Diagnostics** and it's affiliated laboratories to endorse any checks received on my behalf for payments of services provided. I hereby irrevocably assign to **OmniHealth Diagnostics** and it's affiliated laboratories all benefits under any policy of insurance indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action including legal suit, if for any reason my insurance company fails to make payment. This assignment also includes all rights to recover attorney fees and costs for such actions brought by the provider as my assignee.

Patient Signature: _____ **Date:** _____