LIVERFASt™

Test Requisition Form

Account Information

Clinic Name: _____ Clinic Street Address: _____

Phone Number: _____ City: _____ State: _____

Fax Number: _____ Zip: _____ Email: _____

1. Patient Demographics (attach a copy of patient demographics or insurance card) **Patient Medical Record Number:** _____

Last Name: _____ First Name: _____ D.O.B.: _____ Gender: ☐ M ☐ F

Patient Street Address: _____ City: _____ State: _____ Zip: _____

Patient Phone Number: _____ Weight: _____ lbs. Height: _____ ft. _____ inches

Bill to: ☐ Medicare ☐ Commercial ☐ Medicaid

Insurance Co: _____ Insurance ID#: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

2.Test Information

☐ **LIVERFASt 0166U**

3. Diagnosis Information

ICD-10 Codes (ICD Diagnosis codes are mandatory):

The following commonly used diagnosis codes are listed as a convenience only. Ordering physicians should use ICD-10 codes that best describe the reason for performing tests, whether or not that code is listed below.

☐ K76.9 Chronic Liver Disease, Unspecified
☐ K73.9 Chronic Hepatitis, Unspecified
☐ K76.0 Fatty (change of) liver, not elsewhere classified
☐ K70.0 Alcoholic fatty liver
☐ K70.2 Alcoholic fibrosis and sclerosis of liver
☐ K73.0 Chronic persistent hepatitis, not elsewhere classified
☐ K73.1 Chronic lobular hepatitis, not elsewhere classified
☐ K73.2 Chronic active hepatitis, not elsewhere classified
☐ K74.0 Hepatic fibrosis
☐ K74.1 Hepatic sclerosis
☐ K74.2 Hepatic fibrosis with hepatic sclerosis
☐ K74.3 Primary biliary cirrhosis
☐ K74.4 Secondary biliary cirrhosis
☐ K74.69 Other cirrhosis of liver
☐ K75.4 Autoimmune hepatitis
☐ K75.81 Nonalcoholic steatohepatitis (NASH)
☐ B18.0 Chronic viral hepatitis B with delta-agent
☐ B18.1 Chronic viral hepatitis B without delta-agent
☐ B18.2 Chronic viral hepatitis C
☐ B18.8 Other chronic viral Hepatitis
☐ R94.5 Abnormal results of liver function studies
☐ Z86.19 Personal history of other infectious and parasitic diseases

☐ _____ ☐ _____ ☐ _____

4. Electronic Lab Order Requested for Blood Draw

☑ Interlab

5.Phlebotomy Options

☑ In-house ☐ ALTN Location _____ Kit used ☐ Yes ☐ No

☐ Interlab ☐ Mobile Phlebotomy Name of Mobile Phlebotomy _____

6. ABN Notice

I authorize the release of medical or other information to my healthcare Insurer about services described herein and authorize payment directly to Interlab Corp.

Patient's Signature: _____ Date: _____

7. Clinician Information

Clinician Name _____ NPI Number: _____ Fax Number: _____

I am a licensed medical professional. I acknowledge that the test requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer. Note: Tests not ordered by the physician who is treating the beneficiary are not reimbursable. Order codes are updated but CPT Codes are not impacted.

Clinician's Signature: _____ Date: _____

8. Specimen Information

Collection Date _____ Collection Time _____ Collected by _____

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