

DID YOU INCLUDE...

- DIAGNOSIS CODE(S)?
- TEST(S) TO BE PERFORMED?
- PROVIDER FIRST/ LAST NAME?
- WHO TO BILL?

GENERAL LABORATORY REQUEST FORM



Alaska Medical Center

P.O. Box 196604 Anchorage, AK 99519-6604

Phone: (907) 212-3631 Main Lab Fax: (907) 212-3632

ORDERING PROVIDER SIGNATURE: _____

TODAY'S DATE (REQUIRED):		COLLECTION DATE (REQUIRED):		COLLECTION TIME (REQUIRED):		SEX (REQUIRED): <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER		<input type="checkbox"/> STAT Phone: _____		
PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY							DATE OF BIRTH (REQUIRED)			
PATIENT'S FULL LEGAL NAME (REQUIRED)										
LAST:		FIRST:		MI:						
DIAGNOSIS ICD CODE(S) (REQUIRED):					ADDITIONAL COPIES TO:					
<input type="checkbox"/> CLIENT/PHYSICIAN ACCOUNT BILL #: _____ COMPLETE REQUIRED AREAS			<input type="checkbox"/> PATIENT BILL COMPLETE REQUIRED AREAS BELOW			<input type="checkbox"/> INSURANCE COMPLETE ALL AREAS			SUBSCRIBER (LAST, FIRST, MIDDLE)	
GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE)			DATE OF BIRTH		ADDRESS (CITY, STATE, ZIP)					
ADDRESS					PHONE #		PATIENT RELATIONSHIP			
CITY/STATE/ZIP CODE:					INSURANCE CO.					
PT. RELATIONSHIP:					CLAIMS ADDRESS (CITY, STATE, ZIP)					
HOME PHONE NO.:		WORK PHONE NO.:		INSURANCE PHONE		INSURANCE/MEMBER POLICY #		GROUP #		

AMA PROFILES (Epic order) <i>(see reverse for panel definitions)</i>	CHEMISTRY (Epic order)	THERAPEUTIC DRUG LEVELS (Epic Order)	MICROBIOLOGY (Epic order)	URINALYSIS (Epic order)
<input type="checkbox"/> Basic Metabolic Panel (LAB15)	<input type="checkbox"/> Folate (LAB69)	REQUIRED:	Specimen source (REQUIRED) _____	<input type="checkbox"/> Occult Blood, FIT (LAB2502)
<input type="checkbox"/> Comprehensive Metabolic Panel (LAB17)	<input type="checkbox"/> Free T4 (LAB127)	Day of Last Dose: _____	Antibiotics? _____	<input type="checkbox"/> UA w/Micro w/Cult if IND (LAB2480)
<input type="checkbox"/> Electrolyte Panel (LAB16)	<input type="checkbox"/> FSH (LAB86)	Time of Last Dose: _____	<input type="checkbox"/> Wound Culture, Gram Stain	<input type="checkbox"/> UA w/Microscopic if IND (LAB2479)
<input type="checkbox"/> Hepatitis Acute Panel (LAB551)	<input type="checkbox"/> Glucose, Random (LAB82)	<input type="checkbox"/> Digoxin Level (LAB23)	<input type="checkbox"/> Wound Aerobic (LAB897)	<input type="checkbox"/> Urinalysis (dipstick) (LAB347)
<input type="checkbox"/> Lipid Panel no Reflex LDL (LAB2478)	<input type="checkbox"/> HCG, Serum, Quant (LAB143)	<input type="checkbox"/> Dilantin Level (Phenytonin) (LAB31)	<input type="checkbox"/> Wound Anaerobic (LAB233)	<input type="checkbox"/> Urinalysis w/Microscopic (LAB348)
<input type="checkbox"/> Lipid Panel Reflex LDL Direct (LAB18)	<input type="checkbox"/> Hgb A1C (Glyco Hgb) (LAB90)	<input type="checkbox"/> Lithium Level (LAB29)	<input type="checkbox"/> Sterile BF Cult Smr Ana (LAB269)	<input type="checkbox"/> Urine Drug Screen Panel (DAU) (LAB500)
<input type="checkbox"/> Hepatic Function Panel (LAB20)	<input type="checkbox"/> Iron + Transferrin (LAB829)	<input type="checkbox"/> Tacrolimus (FK506) Trough (LAB876)	<input type="checkbox"/> Tissue Culture Smr Ana (LAB898)	<input type="checkbox"/> Vaginal Path DNA Probe (LAB5687)
<input type="checkbox"/> Renal Function Panel (LAB19)	<input type="checkbox"/> Iron, Total (LAB94)	<input type="checkbox"/> Tegretol (Carbamazepine) (LAB21)	<input type="checkbox"/> AFB Culture & Smear (LAB877)	HEMATOLOGY (Epic order)
	<input type="checkbox"/> LH (Luteinizing Hormone) (LAB87)	<input type="checkbox"/> Valproic Acid (Depakote) (LAB24)	<input type="checkbox"/> Blood Culture (LAB462)	<input type="checkbox"/> CBC no diff (LAB294)
	<input type="checkbox"/> Lipase (LAB99)	<input type="checkbox"/> Vancomycin Peak (LAB41)	<input type="checkbox"/> C. diff NAAT (LAB24937)	<input type="checkbox"/> CBC w/Differential (LAB293)
	<input type="checkbox"/> Magnesium (LAB103)	<input type="checkbox"/> Vancomycin Trough (LAB39)	<input type="checkbox"/> Chlamydia/GC PCR (LAB1376)	<input type="checkbox"/> Protine w/INR (LAB320)
CHEMISTRY (Epic order)	<input type="checkbox"/> Phosphorus (LAB113)	SEROLOGY (Epic order)	<input type="checkbox"/> COVID PCR (LAB23057)	<input type="checkbox"/> PTT (APTT) (LAB325)
<input type="checkbox"/> ALT (SGPT) (LAB2363)	<input type="checkbox"/> Potassium (LAB114)	<input type="checkbox"/> Hep B Surface Ab (HbsAb) (LAB472)	<input type="checkbox"/> Ear Culture, gram stain (LAB20400)	<input type="checkbox"/> Reticulocyte Count (LAB296)
<input type="checkbox"/> Amylase (LAB48)	<input type="checkbox"/> Pregnancy Serum Qual (LAB144)	<input type="checkbox"/> Hep B Surface Ag (HbsAg)	<input type="checkbox"/> COVID PCR (LAB23057)	TRANSFUSION MEDICINE (Epic order)
<input type="checkbox"/> AST (SGOT) (LAB131)	<input type="checkbox"/> Pregnancy Urine Qual (LAB437)	<input type="checkbox"/> w/confirmation if +) (LAB471)	<input type="checkbox"/> Eye Culture, gram stain (LAB2310)	<input type="checkbox"/> ABO/RH (LAB895)
<input type="checkbox"/> Bilirubin, Total & Direct (LAB168)	<input type="checkbox"/> Procalcitonin (LAB12835)	<input type="checkbox"/> Hep C Antibody (LAB2375)	<input type="checkbox"/> Giardia Antigen (LAB259)	<input type="checkbox"/> Antibody Screen (LAB278)
<input type="checkbox"/> Bilirubin, Total (LAB50)	<input type="checkbox"/> Progesterone (LAB529)	<input type="checkbox"/> HIV 4th (Ab 1+2 w/Ag) (LAB23457)	<input type="checkbox"/> MRSA/SA NAAT Qual (LAB24325)	<input type="checkbox"/> Fetal Screen w/Reflex (LAB2250)
<input type="checkbox"/> NT-proBNP (LAB1780)	<input type="checkbox"/> Prolactin (LAB531)	<input type="checkbox"/> Quantiferon Gold TB (LAB24955)	<input type="checkbox"/> Ova & Parasite (LAB955)	<input type="checkbox"/> Prenatal Type & Screen (LAB895 & 278)
<input type="checkbox"/> BUN (LAB140)	<input type="checkbox"/> PSA, diagnostic (LAB116)	<input type="checkbox"/> Rheumatoid Factor (RA, RF) (LAB206)	<input type="checkbox"/> Stool Culture (LAB223)	<input type="checkbox"/> RHIG admin date _____
<input type="checkbox"/> Calcium (LAB53)	<input type="checkbox"/> PSA, screening (LAB2268)	<input type="checkbox"/> Rubella Antibody, IGG (LAB496)	<input type="checkbox"/> Strep A DNA Probe NAAT (LAB1369)	<input type="checkbox"/> Direct Coombs (LAB274)
<input type="checkbox"/> Cholesterol, Total (LAB60)	<input type="checkbox"/> PTH Intact & Calcium (LAB813)	<input type="checkbox"/> Treponema Pallidum Ab (LAB12341)	<input type="checkbox"/> Strep A Culture Throat (LAB236)	<input type="checkbox"/> Cord Blood Workup (LAB892)
<input type="checkbox"/> CK Total (LAB62)	<input type="checkbox"/> Testosterone, Total (LAB124)		<input type="checkbox"/> Strep B DNA Probe NAAT (LAB1371)	Specimens Requiring Typenex Blood Bank Band at the Time of Collection
<input type="checkbox"/> Cortisol, Serum (LAB61)	<input type="checkbox"/> Triglycerides (LAB134)		<input type="checkbox"/> Strep B Culture (LAB223)	<input type="checkbox"/> Extra Blood Bank Tube to Hold (LAB286)
<input type="checkbox"/> COVID AB test (LAB25283)	<input type="checkbox"/> TSH Reflex Free T4 (LAB13042)		<input type="checkbox"/> Penicillin Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No (Vaginal/Rectal Sources Only)	<input type="checkbox"/> Type & Screen (LAB276)
<input type="checkbox"/> COVID AG (LAB25341)	<input type="checkbox"/> TSH (LAB129)		<input type="checkbox"/> Urine Culture (LAB239)	_____ # of PRBC Units
<input type="checkbox"/> C-Reactive Protein (LAB149)	<input type="checkbox"/> Uric Acid (LAB141)		<input type="checkbox"/> Urine Source _____	<input type="checkbox"/> IRRADIATED
<input type="checkbox"/> Creatinine (LAB66)	<input type="checkbox"/> Vitamin B-12 (LAB2466)			<input type="checkbox"/> WASHED
<input type="checkbox"/> CRP, High Sensitivity (LAB150)	<input type="checkbox"/> Vitamin D Total (LAB2301)			
<input type="checkbox"/> Estradiol (LAB523)				
<input type="checkbox"/> Ferritin (LAB68)				

ADDITIONAL TESTS/COMMENTS:

LAB USE ONLY:
REQUISITION #: _____
MEDICAL RECORD #: _____

MEDICAL NECESSITY STATEMENT FOR PHYSICIANS

The ordering physician certifies that the tests ordered and to be billed to Medicare are medically necessary and understands that all available tests may be ordered individually and, profiles may, where appropriate, be billed separately. Only tests that the ordering physician believes appropriate for patient care should be ordered. Medicare will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes. ICD-10 CM diagnosis code(s) **must** be provided for each test ordered.

AMA Panels

<p>Comprehensive Metabolic Panel 80053 Sodium Potassium Chloride Carbon Dioxide Glucose Creatinine BUN Calcium Bilirubin, total Albumin AST (SGOT) Alkaline Phosphatase Protein, total ALT (SGPT)</p>	<p>Electrolyte Panel 80051 Sodium Potassium Chloride Carbon Dioxide</p> <p>Basic Metabolic Panel 80048 Sodium Potassium Chloride Carbon Dioxide Glucose Creatinine BUN Calcium</p>	<p>Renal Function Panel 80069 Sodium Potassium Chloride Carbon Dioxide Glucose Creatinine BUN Calcium Albumin Phosphorus, inorganic (Phosphate)</p>	<p>Hepatitis Acute Panel 80074 Hep B surface antigen (HBsAg) Hep B core antibody (HBcAb), IgM Hep C antibody Hep A antibody, IgM</p> <p>Lipid Panel 80061 Cholesterol, total Triglycerides HDL cholesterol LDL cholesterol (calculated)</p>	<p>Liver Panel 80076 Albumin Bilirubin, total and direct ALT (SGPT) AST (SGOT) Alkaline Phosphatase Protein, total</p> <p>Obstetric Panel 80055 CBC Hep B Surface antigen (HbsAg) Antibody, Rubella RPR ABO/Rh type Antibody screen</p>
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REFLEX/CONFIRMATORY TESTING NOTICE

It is the policy of Providence Alaska Medical Center laboratory to perform reflex or confirmatory test automatically on microbiological cultures (gram stain, bacterial identification and susceptibility, if warranted, unless otherwise requested), negative Rapid Strep Screen (culture), positive HIV (Western Blot), positive Hepatitis B Surface Antigen test, CSF or Body Fluid Cell Count, Lipid Panel Triglyceride >400mg/dL (direct measure LDL), and CSF Cell Count, Malaria smear, CBC/CBC w/Differential (Pathologist review). Many of these tests are also available without confirmation, if desired. Transfusion Medicine will perform additional testing as needed to identify auto- and allo-antibodies, and/or to provide compatible blood products for transfusion. The subsequent testing is performed at additional charge. Medical necessity must apply to the reflex test also. Refer to Providence Alaska Medical Center laboratory's Testing Manual for details.

**MORE PATIENT SERVICE CENTER
LOCATIONS TO SERVE YOU BETTER**

Providence Health Park
3841 Piper Street, Suite T-211
Anchorage, AK 99508
Phone (907) 212-5815
Fax (907) 212-3632

Tudor Square
3425 E. Tudor Road
Anchorage, AK 99504
Phone (907) 644-8252
Fax (907) 212-3632

Southside Anchorage
345 W 104th, Suite 300
Anchorage, AK 99515
Phone (907) 212-7413
Fax (907) 212-3632

For hours of operation and testing directory
go to: <http://alaska.providence.org>

Note: When a patient visits a patient service center, photo identification and insurance cards are required.

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- DIAGNOSIS CODE(S)?
- TEST(S) TO BE PERFORMED?
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TODAY'S DATE (REQUIRED):	COLLECTION DATE (REQUIRED):	COLLECTION TIME (REQUIRED):	SEX (REQUIRED): <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	<input type="checkbox"/> STAT Phone: _____
<i>PLEASE PRINT CLEARLY</i> ALL INFORMATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY			DATE OF BIRTH (REQUIRED)	Fax #: _____ <input type="checkbox"/> Fax Results Immediately
PATIENT'S FULL LEGAL NAME (REQUIRED)				FASTING: <input type="checkbox"/> Yes <input type="checkbox"/> No
LAST:	FIRST:	MI:		
DIAGNOSIS ICD CODE(S) (REQUIRED):		ADDITIONAL COPIES TO:		
<input type="checkbox"/> CLIENT/PHYSICIAN ACCOUNT <input type="checkbox"/> PATIENT BILL COMPLETE REQUIRED AREAS BELOW <input type="checkbox"/> INSURANCE COMPLETE ALL AREAS		SUBSCRIBER (LAST, FIRST, MIDDLE)		DATE OF BIRTH
GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE)		DATE OF BIRTH	ADDRESS (CITY, STATE, ZIP)	
ADDRESS		PHONE #	PATIENT RELATIONSHIP	
CITY/STATE/ZIP CODE:		INSURANCE CO.		
PT. RELATIONSHIP:		CLAIMS ADDRESS (CITY, STATE, ZIP)		
HOME PHONE NO.:	WORK PHONE NO.:	INSURANCE PHONE	INSURANCE/MEMBER POLICY #	GROUP #

AMA PROFILES (Epic order) <i>(see reverse for panel definitions)</i>	CHEMISTRY (Epic order)	THERAPEUTIC DRUG LEVELS (Epic Order)	MICROBIOLOGY (Epic order)	URINALYSIS (Epic order)
<input type="checkbox"/> Basic Metabolic Panel (LAB15) <input type="checkbox"/> Comprehensive Metabolic Panel (LAB17) <input type="checkbox"/> Electrolyte Panel (LAB16) <input type="checkbox"/> Hepatitis Acute Panel (LAB551) <input type="checkbox"/> Lipid Panel no Reflex LDL (LAB2478) <input type="checkbox"/> Lipid Panel Reflex LDL Direct (LAB18) <input type="checkbox"/> Hepatic Function Panel (LAB20) <input type="checkbox"/> Renal Function Panel (LAB19)	<input type="checkbox"/> Folate (LAB69) <input type="checkbox"/> Free T4 (LAB127) <input type="checkbox"/> FSH (LAB86) <input type="checkbox"/> Glucose, Random (LAB82) <input type="checkbox"/> HCG, Serum, Quant (LAB143) <input type="checkbox"/> Hgb A1C (Glyco Hgb) (LAB90) <input type="checkbox"/> Iron + Transferrin (LAB829) <input type="checkbox"/> Iron, Total (LAB94) <input type="checkbox"/> LH (Luteinizing Hormone) (LAB87) <input type="checkbox"/> Lipase (LAB99) <input type="checkbox"/> Magnesium (LAB103) <input type="checkbox"/> Phosphorus (LAB113) <input type="checkbox"/> Potassium (LAB114) <input type="checkbox"/> Pregnancy Serum Qual (LAB144) <input type="checkbox"/> Pregnancy Urine Qual (LAB437) <input type="checkbox"/> Procalcitonin (LAB12835) <input type="checkbox"/> Progesterone (LAB529) <input type="checkbox"/> Prolactin (LAB531) <input type="checkbox"/> PSA, diagnostic (LAB116) <input type="checkbox"/> PSA, screening (LAB2268) <input type="checkbox"/> PTH Intact & Calcium (LAB813) <input type="checkbox"/> Testosterone, Total (LAB124) <input type="checkbox"/> Triglycerides (LAB134) <input type="checkbox"/> TSH Reflex Free T4 (LAB13042) <input type="checkbox"/> TSH (LAB129) <input type="checkbox"/> Uric Acid (LAB141) <input type="checkbox"/> Vitamin B-12 (LAB2466) <input type="checkbox"/> Vitamin D Total (LAB2301)	REQUIRED: Day of Last Dose: _____ Time of Last Dose: _____ <input type="checkbox"/> Digoxin Level (LAB23) <input type="checkbox"/> Dilantin Level (Phenytonin) (LAB31) <input type="checkbox"/> Lithium Level (LAB29) <input type="checkbox"/> Tacrolimus (FK506) Trough (LAB876) <input type="checkbox"/> Tegretol (Carbamazepine) (LAB21) <input type="checkbox"/> Valproic Acid (Depakote) (LAB24) <input type="checkbox"/> Vancomycin Peak (LAB41) <input type="checkbox"/> Vancomycin Trough (LAB39)	Specimen source (REQUIRED) _____ Antibiotics? _____ Wound Culture, Gram Stain <input type="checkbox"/> Wound Aerobic (LAB897) <input type="checkbox"/> Wound Anaerobic (LAB233) <input type="checkbox"/> Sterile BF Cult Smr Ana (LAB269) <input type="checkbox"/> Tissue Culture Smr Ana (LAB898) <input type="checkbox"/> AFB Culture & Smear (LAB877) <input type="checkbox"/> Blood Culture (LAB462) <input type="checkbox"/> C. diff NAAT (LAB24937) <input type="checkbox"/> Chlamydia/GC PCR (LAB1376) <input type="checkbox"/> COVID PCR (LAB23057) <input type="checkbox"/> Ear Culture, gram stain (LAB20400) <input type="checkbox"/> Eye Culture, gram stain (LAB2310) <input type="checkbox"/> Giardia Antigen (LAB259) <input type="checkbox"/> MRSA/SA NAAT Qual (LAB24325) <input type="checkbox"/> Ova & Parasite (LAB955) <input type="checkbox"/> Stool Culture (LAB223) <input type="checkbox"/> Strep A DNA Probe NAAT (LAB1369) <input type="checkbox"/> Strep A Culture Throat (LAB236) <input type="checkbox"/> Strep B DNA Probe NAAT (LAB1371) <input type="checkbox"/> Penicillin Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No (Vaginal/Rectal Sources Only) <input type="checkbox"/> Urine Culture (LAB239) <input type="checkbox"/> Urine Source	<input type="checkbox"/> Occult Blood, FIT (LAB2502) <input type="checkbox"/> UA w/Micro w/Cult if IND (LAB2480) <input type="checkbox"/> UA w/Microscopic if IND (LAB2479) <input type="checkbox"/> Urinalysis (dipstick) (LAB347) <input type="checkbox"/> Urinalysis w/Microscopic (LAB348) <input type="checkbox"/> Urine Drug Screen Panel (DAU) (LAB500) <input type="checkbox"/> Vaginal Path DNA Probe (LAB5687)
CHEMISTRY (Epic order) <input type="checkbox"/> ALT (SGPT) (LAB2363) <input type="checkbox"/> Amylase (LAB48) <input type="checkbox"/> AST (SGOT) (LAB131) <input type="checkbox"/> Bilirubin, Total & Direct (LAB168) <input type="checkbox"/> Bilirubin, Total (LAB50) <input type="checkbox"/> NT-proBNP (LAB1780) <input type="checkbox"/> BUN (LAB140) <input type="checkbox"/> Calcium (LAB53) <input type="checkbox"/> Cholesterol, Total (LAB60) <input type="checkbox"/> CK Total (LAB62) <input type="checkbox"/> Cortisol, Serum (LAB61) <input type="checkbox"/> COVID AB test (LAB25283) <input type="checkbox"/> COVID AG (LAB25341) <input type="checkbox"/> C-Reactive Protein (LAB149) <input type="checkbox"/> Creatinine (LAB66) <input type="checkbox"/> CRP, High Sensitivity (LAB150) <input type="checkbox"/> Estradiol (LAB523) <input type="checkbox"/> Ferritin (LAB68)	HEMATOLOGY (Epic order) <input type="checkbox"/> CBC no diff (LAB294) <input type="checkbox"/> CBC w/Differential (LAB293) <input type="checkbox"/> Protine w/INR (LAB320) <input type="checkbox"/> PTT (APTT) (LAB325) <input type="checkbox"/> Reticulocyte Count (LAB296)			
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Specimens Requiring Typenex Blood Bank Band at the Time of Collection <input type="checkbox"/> Extra Blood Bank Tube to Hold (LAB286) <input type="checkbox"/> Type & Screen (LAB276) _____ # of PRBC Units <input type="checkbox"/> IRRADIATED <input type="checkbox"/> WASHED				

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LAB USE ONLY:
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Fax (907) 212-3632

Tudor Square
3425 E. Tudor Road
Anchorage, AK 99504
Phone (907) 644-8252
Fax (907) 212-3632

Southside Anchorage
345 W 104th, Suite 300
Anchorage, AK 99515
Phone (907) 212-7413
Fax (907) 212-3632

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