MMZ Clinical Laboratories Inc.

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Last / First / MI			
Address / Apt#			
City / ST / Zip			
County			
Insurance Name			
Member ID #		DOB	
Group #		SSN	
SEX ☒M ☒F	Weight:	Phone	

CLIENT INFORMATION

Received Date:

Practice / Account #
Address
City / ST / Zip
Phone # (210)849-6656
Ordering Provider
Provider Signature

Specimen Collection Information
Date of Service_____ Time:_____☒am ☒pm
Phlebotomist Name_____ Fasting: ☒yes ☒no
B - Blue L - Lavender TT - Tiger Top R - Red G - Green Y - Yellow G - Gray

**** FAILURE TO COMPLETE ALL FIELDS MAY DELAY PATIENT RESULTS. PLEASE ATTACH DEMOGRAPHICS AND COPY OF CURRENT INSURANCE. ****

☐ COMPLETE WELLNESS (3TT, 2L)
Nutritional | Heart | Hormone | Metabolic
(Fasting) Wellness, Internal, Family, Cardio, Endo

☐ ADVANCED METABOLIC (2TT, 1L)
Nutritional | Hormone | Metabolic
(Non-Fasting) Surgery, Gynecology, Low-T, Other Sub-Specialties

☐ STANDARD (1TT,1L)
Nutritional | Hormone
(Non-Fasting) Pain, Psychiatry, Dermatology,- Allergy

Please check appropriate selections that address your patient's needs. Tests can be ordered individually.

☐ **Nutritional Profile** 2TT, 1L

- ☐ CBC with Diff
- ☐ CK
- ☐ Folate
- ☐ Uric Acid
- ☐ Vitamin B12
- ☐ Retic
- ☐ Iron Profile
  - ☐ Iron
  - ☐ TIBC
  - ☐ Ferritin
  - ☐ Transferrin
- ☐ Bone Profile
  - ☐ Vitamin D (25 - OH)
  - ☐ PTH
  - ☐ Rheumatoid Factor

☐ **Heart Profile** 2L, 2TT

- ☐ Lipid Profile
  - ☐ Cholesterol (Total)
  - ☐ LDL - C
  - ☐ HDL - C
  - ☐ Triglycerides
  - ☐ Apolipoprotein A1
- ☐ Cardiac Risk Profile
  - ☐ BNP
  - ☐ CRP-hs
  - ☐ Homocysteine
  - ☐ CRP
- ☐ Diabetic Profile
  - ☐ HbA1c

☐ **Hormone Profile** 1T

- ☐ Hormone Balance
  - ☐ Cortisol
  - ☐ DHEA-S
  - ☐ Estradiol
  - ☐ FSH
  - ☐ LH
  - ☐ SHBG
  - ☐ Testosterone (Free/Total)
  - ☐ Progesterone
  - ☐ Prolactin
- ☐ Thyroid Profile
  - ☐ TSH
  - ☐ T3 (Free)
  - ☐ T4 (Free)
  - ☐ Anti-TPO
  - ☐ Anti-TG
  - ☐ T-Uptake
  - ☐ Total T4
- ☐ PSA (Free/Total) (Men 37+)
- ☐ BHCG (Women 40 and Under)

☐ **Metabolic Profile** 1TT

- ☐ Electrolyte Profile
  - ☐ Calcium
  - ☐ Chloride
  - ☐ Glucose
  - ☐ Carbon Dioxide
  - ☐ Potassium
  - ☐ Sodium
  - ☐ Magnesium
  - ☐ Phosphorus
- ☐ Renal Profile
  - ☐ BUN
  - ☐ Creat with eGFR
- ☐ Pancreatic Profile
  - ☐ Amylase (Pancreatic)
  - ☐ Lipase
- ☐ Liver Profile
  - ☐ ALP
  - ☐ ALT
  - ☐ AST
  - ☐ Albumin
  - ☐ Protein (Total)
  - ☐ Bilirubin (Total)
  - ☐ Bilirubin (Direct)
  - ☐ GGT
  - ☐ LDH

☐ **COVID-19 /IgG/IgM(Ab)**

☐ **Hepatitis** 1TT

- ☐ Hepatitis A IgG
- ☐ Hepatitis A IgM
- ☐ Hepatitis B Core Antibody
- ☐ Hepatitis B Surface Antibody (Quant)
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis C Virus

☐ **OTHER***

* Please be sure to submit an additional tube for"other" testing

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

* Test not listed on requisition may be sent out and may extend the turn around time.

Diagnosis Codes REQUIRED (ICD-10)

Note: Please write ALL applicable codes that best describes the reasons for performing EACH test.

1._____ 2._____ 3._____ 4._____
5._____ 6._____ 7._____ 8._____

Patient Problem List / Clinical Note

_____
_____
_____

Assignment of Benefits & Consent

In consideration of services rendered, I transfer and assign any benefits of insurance to **MMZ** and authorize MMZ to submit claims on my behalf directly to my private health insurance provider/health plan. I authorize MMZ to release any medical information needed for claim of payment purposes to Medicare or other insurance carrier, or health plan providing my medical benefits. I understand that MMZ is an out-of-network provider and my provider may hold an ownership interest in this laboratory, and as such may receive a return on investment from this interest. I understand that I have the option of obtaining lab services from another facility and that, upon my request, will be provided a list of alternative lab facilities. I understand that if the insurance pays me directly for services rendered by MMZ, I am responsible for forwarding te payment to MMZ. I agree that this Assignment of Benefits and Consent will cover all medical services rendered by **MMZ** to me until such authorization is revoked in writing by me.

Patient Signature: _____ Date___/___/_____

(A) Notifier(s): _____

(B) Patient Name: _____ **(CI Identification Number:** _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: if Medicare doesn't pay for (D)_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need, We expect Medicare may not pay for the (D)_____below.

(D)_____	(E) Reason Medicare May Not Pay:	(E) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- **Read this notice, so you can make an informed decision about your care.**
- **Ask us any questions that you may have after you finish reading.**
- **Choose an option below about whether to receive the (D)_____ listed above.**

  Note: IF you choose option 1 or 2, we may help you to use any other insurance that you might have but Medicare cannot require to do this.

(G) Options: Check only one box. We Cannot choose a box for you.

❑ **OPTIONS 1.** I want the (D)_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment which is sent to me on a Medicare Summary Notice (MSN), I Understand that if Medicare doesn't pay, I am responsible for but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you less co-pays or deductables.

❑ **OPTIONS 2.** I want the (D)_____listed above but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTIONS 3.** I want the (D)_____listed above I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This Notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, **call 1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048). Signing below means that you have received a copy and understand this notice.

(I) Signature: **(J)Date**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggested for improving this for please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Office, Baltimore, Maryland 21244-1850