inspire DIAGNOSTICS

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CLINIC/PHYSICIAN INFORMATION

PATIENT'S/ INSURANCE INFORMATION

(Last Name) (First Name)

_____/_____/_____ ☐ M ☐ F AGE _____
(D.O.B)

(Address)

(City, State, Zip)

(Phone Number)

(Insurance)

(Policy Number) (Group #)

☐ Insurance ☐ Self-Pay ☐ M/care ☐ M/aid ☐ Billing Info Attached

SPECIMEN DATA

Fasting Patient: ☐ Yes ☐ No

Date Collected: _____/_____/_____ Time: _____:_____ AM / PM

Collector : _____

ICD-10 DIAGNOSIS CODES

_____ _____

_____ _____

_____ _____

Many payers including Medicare and Medicaid have medical necessity requirements. You should only enter those tests which are medically necessary for the diagnosis and treatment of the patient.

ORDERING PHYSICIAN

PATIENT AUTHORIZATION

As courtesy, Inspire Diagnostics will make every reasonable effort to obtain reimbursement for its tests. In consideration of services rendered, I agree that Inspire Diagnostics will furnish to my designated insurance carrier the information on this form necessary for reimbursement. I hereby authorize services to be performed and assign that benefits payable to the Lab. I understand that if any insurer doesn't pay and denies the claim as an uncovered service, I am responsible for payment. If my insurer pays me directly, I agree to endorse the check and forward to Inspire Diagnostics within 30 days. I understand that I am responsible for any amounts not paid by insurer for reasons including but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.
I authorize my insurance benefits to be paid directly to Inspire Diagnostics for services I have received. Inspire Diagnostics is authorized to bill my insurance provider and to receive payment of benefits for the tests my physician orders. I further authorize Inspire Diagnostics and my physician to release to my insurance provider any medical information necessary to this claim.

(Patient Signature) (Date)

TESTS REQUESTED

L = Lavender
U = Urine
S = Serum on Spun Barrier Tube (SST)

✓	PANELS	ICD-10
	CBC w/ Diff (L)	
	LIPID PANEL (S)	
	CHOL TOTAL	
	TRIG	
	HDL Chol	
	LDL Chol	

	COMPLETE METABOLIC PANEL (S)			
	BUN		Sodium	
	Calcium		Albumin	
	Chloride		Total Protein	
	CO2		Total Bilirubin	
	Creatinine		AST	
	Glucose		ALT	
	Potassium		ALP	

	BASIC METABOLIC PANEL (S)		INDIVIDUAL PROCEDURES (S)	
	BUN		Phosphorus (S)	
	Calcium		**Vitamin D (S)**	
	Chloride		**Vitamin B12 (S)**	
	CO2		Ferritin (S)	
	Creatinine		Folate (S)	
	Glucose		**Testosterone (S)**	
	Potassium		Estradiol (S)	
	Sodium		PSA, Total (S)	
	LIVER / HEPATIC PANEL (S)		PSA, Free (S)	
	ALP	Total Protein	FSH (S)	
	ALT	Albumin	**Hs-CRP (S)**	
	Total Bilirubin	AST	Cortisol (S)	
	Direct Bilirubin		Magnesium (S)	
	IRON (S)	**STDs**	Progesterone (S)	
	IRON	Hep C Ab (S)	Prolactin (S)	
	Ferritin	Syphilis (S)	SHBG (S)	
		HIV ½ screen (L)	LH (S)	
	THYROID (S)		DHEA-S (S)	
	FT3	TT3	GGT (S)	
	TSH	FT4	LDH (S)	
			Anti-TPO (S)	

	Additional In-House Testing		
	Hemoglobin A1C (L)		TT4 (S)
	Sed Rate/ESR (L)		Uric Acid (S)
	Lithium (S)		Urinalysis (U)
	Valproic Acid / Depakote (S)		Protein/Creatinine Ratio / ACR (U)

PHYSICIAN AUTHORIZATION

Provider Signature (Required by Medicare) (Date)