United Clinical Laboratories

Submitter may be billed if complete patient and billing information is not provided.

REQUIRED INFORMATION

Patient Information: *PLEASE PRINT*

Record/History/Office ID#

Patient SS# (optional)

Patient Name

Patient DOB ☐ Male ☐ Female

Patient Address

City/State/Zip

Phone (H) Phone (W)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's Employer

Physician: Last First

Order date Initials Source Facility

Bill To: ☐ Account ☐ Medicare* ☐ Medicaid ☐ UHC-RV* ☐ Insurance* ☐ Patient

Billing Information:

***Please list or attach the following insurance information**

Ins. Co. Name

Ins. Co. Address

City/State/Zip

Policy # Group #

Group Name

Pt Relation to insured ☐ Self ☐ Spouse ☐ Depend ☐ Other

Insured's SS# (optional)

Insured's Name

Insured's DOB ☐ Male ☐ Femaie

Insured's Address

City/State/Zip

Does Patient have other Insurance? ☐ Yes ☐ No

If yes list/send info

☐ **STAT** ☐ **Expedite** ☐ **Call Results to** ☐ **FAX to**

**Indicates that the tests has a Medicare Medical Necessity Coding Policy. Note: Medicare pays only for panels if all tests are medically necessary.

iCD-10 Code **HEMATOLOGY**

iCD-10 Code **COAGULATION**

iCD-10 Code **URINALYSIS**

iCD-10 Code **SEROLOGY**

iCD-10 Code **BLOOD BANK**

iCD-10 Code **CHEMISTRY**

iCD-10 Code **MICROBIOLOGY**

iCD-10 Code **OTHER**