OSF System Laboratory Client Clinical (Green) Requisition Form Instructions

Please utilize the Client Clinical (Green) requisition for Clinical tests only. Cytology/Surgical Pathology tests have a separate requisition (Blue) to utilize for specimen submission.

Requisition Field	Instructions/Tips for filling out	Required field?
① Bill to Insurance or Client/Office bill	Check/select one or the other. If Bill to Insurance, please attach a copy of both the front and back of the patient's insurance card. **Note: OSF must bill according to the option you check (client takes full accountability for billing type selected).**	YES
② Patient's Name (Last and First)	Clearly document patient's full legal last and first name. Do not use nicknames.	YES
② MI-Patient's Middle initial	Document on form if known.	NO
② Date of Birth	Patient's Date of Birth as it appears on their Birth Certificate.	YES
② Patient's Address	Clearly document patient's address.	NO
② Patient's phone number	Patient's primary phone number.	NO
② Patient's Social Security Number	Patient's Social Security Number. While this field is not mandatory, providing it acts as an additional patient identifier.	NO
③ Advanced Beneficiary Notice	You **MUST** issue an ABN when there is any possibility to expect that the test is not deemed reasonable and necessary under Medicare Program standards. If you believe that a test subject to a <u>frequency limitation</u> exceeds the Medicare Program frequency limits for test ordering, you **MUST** issue an ABN before you collect and order the test. With this requirement, you must evaluate test frequency limits and look up how many times the test was ordered during the specific timeframe for that patient. **Failure to submit an ABN to OSF in these cases, resulting in claim denial, will result in a service charge to your office.**	YES
④ Authorizing Provider	Clearly document Authorizing Provider's complete first and last name. **Dr. Bob or Dr. Smith are not acceptable**.	YES
⑤ Duplicate Report	If you would like a duplicate report sent, provide a full first and last name, along with current contact information.	NO
⑥ Collector's Initials	Clearly document the initials of the person collecting the sample.	YES
⑦ Fasting	Please denote whether or not the patient has fasted for 12 hrs.	YES
⑧ Collected Date and Time	Please denote the collection date and collection time.	YES
⑨ ICD Diagnosis Code	**ICD Code is REQUIRED.** All requests must be accompanied by a valid alpha-numeric ICD diagnosis code, as to establish medical necessity for tests ordered. If the ICD code is not provided and/ or does not meet coverage requirements, this can result in test and/or reimbursement delays.	YES
⑩ Test Selection	Place an "X" in each individual box to select that test. Some boxes require additional information, such as site where sample was collected.	YES