

# Guidelines for Filling Out a Beaumont Clinical Requisition

**Beaumont**® | HEALTH SYSTEM  
 Beaumont Laboratory  
 Phone 800-551-0488 or Fax 248-551-1151

## Patient Information / Billing Information (Please Print)

Pt Last Name	First	M	Birthdate	Beaumont Patient #	Date Collected	Time Collected	Urine Vol _____ ml/ _____ hrs.	
Patient Social Security (last 4 digits only)		Pt. Telephone #	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Copy to: (Indicate physician full name & address or office fax number)			<input type="checkbox"/> AM <input type="checkbox"/> PM	
Responsible Party's Name			← <b>STAT</b> ← Specimen is <input type="checkbox"/> Random <input type="checkbox"/> Fasting				<b>LAB USE ONLY</b>	
Street Address							# Rec	QA Section
City, State, Zip			<b>Ordering Physician</b> Indicate ordering physician name, order date and, when possible, obtain signature of physician or non-physician practitioner.				SST	Frozen
Primary Insurance Name							Lav	Light Protect
Identifying #'s			<b>INSURANCE INFORMATION:</b> Provide health insurance name, address and group numbers - OR - provide a copy of the insurance card front and back.				Blue	AER Swab
Address							Red	ANA Swab
Secondary Insurance Name/Identifying #'s			<b>DATE REQUESTED</b> Ordering Physician or Qualified Nonphysician Practitioner Signature:				Gray	Viral
							Pink	CBair
			<b>REQUIRED: Please provide diagnosis below:</b> A list of commonly used ICD-10 diagnosis codes is provided as a reference tool to help your practice transition to using the new code set.				Navy	Sterile Cup
							Green	Slides
			<b>REQUISITION NUMBER AND VERSION DATE:</b> Refer to lower left corner of the footer. If your current office stock for this requisition (6626) is not dated 06/09/15, please contact Beaumont Laboratory Customer Service at 1-800-551-0488 for assistance. Once in-date requisitions are received, please discard all unused outdated requisitions from your office stock.				Blood Cult	Urea/Myco
							Pour Over	O&P Kit
			<b>TESTS / INSTRUCTIONS / REMARKS</b>				Urine Cup	Stool OBFIT
							Urine Tube	Stool
			<b>WHITE &amp; PINK COPY</b>				Urine Cult Tube	24 Hr. Urine
							Other	

Print first and last name, address, city, state, zip of the physician to receive copy of the report. For fax to requests, include physician full name, the words "fax to" and the office fax

Complete patient full legal name, date of birth and one additional identifier:  
 - Beaumont Patient #  
 - last 4 digits of SS#  
 - patient phone # or  
 - patient's address if same as billing address.

MUST write in the appropriate diagnosis code(s) or narrative description of the diagnosis, symptom, or complaint.

Health insurance plans, including but not limited to Medicare/Medicaid will only reimburse for services that are medically necessary for the treatment or diagnosis of the patient. Routine screening tests typically are not covered. The ordering physician or practitioner must specify medically appropriate diagnosis codes (or provide a narrative description of the diagnosis, symptom, or complaint) that are supported by the patient medical record for each test ordered, including tests listed as part of organ or disease-oriented panels. ▲ Advance Beneficiary Notice (ABN) may be required

**REQUIRED: Please provide diagnosis below:**  
 A list of commonly used ICD-10 diagnosis codes is provided as a reference tool to help your practice transition to using the new code set.

TESTS / INSTRUCTIONS / REMARKS

6626 060915 OS8

WHITE – Send To Beaumont Laboratory • PINK – Client Retain For Your Record

Most Beaumont requisitions include detailed instructions for completing a requisition as well as specimen collection information on the reverse side of the white and pink copy.

# WHITE & PINK COPY

A MEMBER LABORATORY - JVHL (JOINT VENTURE HOSPITAL LABORATORIES)