



THE UNIVERSITY OF
CHICAGO
MEDICINE

UChicago MedLabs
5841 S. Maryland Avenue
Room TW005, Chicago, IL 60637
Phone 888-718-UCML Fax 773-702-4633



1. PATIENT INFORMATION – Required

Name _____
DOB ____/____/____ Sex ____ SS# ____/____/____
Street _____
City _____ State _____ Zip _____
Phone (____) _____ - _____

2. CLIENT INFORMATION - Required

Institution/Group Practice: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Ordering Physician _____ NPI _____

3. BILLING CLASSIFICATION: Check only one box. If no box is checked, UChicago MedLabs will bill Client.

[] **BILL CLIENT**

Client Account Code: _____

[] **BILL PATIENT INSURANCE** Please check for HMO authorization.
Complete Section 4

☐ Check here if prior authorization/ referral form is attached. Failure to include may result in coverage denial.

☐ Check here if patient is self-pay and is aware that they will be billed for our services. Bills will be sent to the address listed in box 1.

Patient Signature _____

4. PATIENT INSURANCE INFORMATION ** Please attach a copy of the front/back of patient's insurance card(s) **

Subscriber (if different from patient) _____ DOB ____/____/____ Relationship _____ SS# ____/____/____

Primary Insurance Co. _____

Secondary Insurance Co. _____

Policy Number _____ Group Number _____

Policy Number _____ Group Number _____

Insurance Company Address _____

Insurance Company Address _____

5. SPECIMEN INFORMATION – Required

Diagnosis: _____ **Collect Date:** ____/____/____ **ICD10#:** _____

6. REQUESTED TESTS

AEROBI ISOLATE ID, ADDL METHOD	COMPREHENSIVE METABOLIC PNL	FERRITIN	LACTATE DEHYDROGENASE	CULTURE, STOOL
ALANINE AMINO (ALT) (SGPT)	CONCH INFECTION AGENT	FOLIC ACID; SERUM	LIPID PANEL	SUSCPTIBILITY MICRO
ALBUMIN; SERUM	CORTISOL TOTAL	GIC AMPLIFIED PROBE ASSAY	OVA & PARASITES	TACROLIMUS
AMIKACIN	C-REACTIVE PROT	GLUCOSE ASSAY	PARATHORMONE	TB CELL MEDIATED IMMUN MEASMT
ANA FLUORSCT AB SCREEN	C-REACTIVE PROTEIN HI SENS	GLYCOSYLATED HEMOGLOBIN A1c	PHOSPHORUS INORGANIC	TESTESTOSTERONE
ASP AMINO (AST)(SGOT)	CREATINE PHOSPHOKINASE-SERUM	HEPATIC FUNCTION PANEL	PREALBUMIN	THYROXINE; FREE
BASIC METABOLIC PANEL	CREATININE,SERUM	HEPATITIS B SURFACE ANTIBODY	PROLACTIN	THYROXINE; TOTAL
C DIFF TOXIN GENES AMP PROBE	CREATININE,URINE	HEPATITIS C ANTIBODY	PROTEIN, URINE QUANT	TRIGLYCERIDES, SERUM
CALCIUM, SERUM	CULTURE, SEROLOGIC TYPING	HIV1 ANTG HIV1 & HIV2 AB	PROTHROMBIN TIME (PT)	TRIIODOTHYRONINE T3; TOTAL (TT3)
COMPLETE BLOOD COUNT	CULTURE, AEROBIC	HIV-1 QUANT	PSA CANCER SCREEN	URIC ACID, SERUM
CBC, NO DIFF	CULTURE, AFB	IMMUNOGLOBULIN IGA, QUANT.	RENAL FUNCTION PANEL	URINALYSIS W/ MICROSCOPY
MAGNESIUM	CULTURE, URINE	IMMUNOGLOBULIN IGG, QUANT.	RHEUMATOID FACTOR	URINE CHEM SCRNR, AUTOMATED
THYROID STIM HORMONE (TSH)	CULTURE,FUNGI,ISOLAT,OTH SRC	IMMUNOGLOBULIN IGM, QUANT.	RPR SCREEN	URINE MICROALBUMIN QUANT
CHLAMYDIA AMPLIFIED PROBE ASSAY	VIT B12 (CYANOCOBALAMIN)	HEPATITIS B SURF INFCT ANTIGEN	SED RATE ERYTHROCYTE (ESR)	VANCOMYCIN
COMPLEMENT C-3	DNA ANTIBODY, NATIVE/DS	INFECT AG SHIGA-LIKE TOXIN 1 & 2	SEX HORM BINDG GLOBULIN	VENIPUNCTURE
COMPLEMENT C-4	ENA SS-A ANTIBODY ID	IRON	SMEAR, ACID FAST STAIN	VITAMIN D 25 HYDROXY
COMPLEX SPECIAL STAIN TRICHROME	ENA SS-B ANTIBODY ID	IRON BINDING CAPACITY	SMEAR, GRAM STAIN	ZINC