Health Alliance™
Alliance Employee Health
Phone 513-585-6600
Fax 513-585-6525

Recommended Precautions Following an Exposure

For individuals who have been exposed to a blood-borne pathogen the following are the Centers for Disease Control and Prevention (CDC) recommendations:

- Refrain from blood, semen, or organ donation for 6 months
- Prevent or limit the exchange of body fluids in your sexual activities for 6 months
- Avoid pregnancy and breast-feeding for 6 months. **If an exposed woman is breastfeeding, she does not need to discontinue after exposure to Hepatitis B or Hepatitis C infected blood.**
- Report to Alliance Employee Health symptoms such as constant fatigue, loss of appetite, recurrent fever, light colored stool, aching muscles and joints, nausea, vomiting, yellow color to skin or whites of eyes, dark urine, itching skin, swollen lymph glands, rapid weight loss

I acknowledge that I have received information appropriate to my exposure and have had the opportunity to discuss information.

Employee signature:_____

Date:_____

SIGN AND FAX THIS FORM TO ALLIANCE EMPLOYEE HEALTH AT 585-6525

Health Alliance™
Alliance Employee Health
Phone 513-585-6600
Fax 513-585-6525

INFORMED CONSENT TO TEST FOR HUMAN IMMUNODEFICIENCY VIRUS

1. What is the HIV Antibody Test?

Detecting HIV involves testing blood for antibodies to the human immunodeficiency virus—the virus that causes AIDS. If testing finds these antibodies, a series of various tests will then be done on the same blood sample to make sure the results of the first test were accurate. In some cases, further testing even beyond that may be required to confirm the diagnosis.

What does this mean to you? A positive test result means that you have been infected with the AIDS virus, but it does not mean you have AIDS. If you test positive, it's very important that you learn what treatment is available and how to avoid infecting others.

A negative test result means that you are probably not infected with the AIDS virus; however, it takes time for the body to produce these telltale antibodies. If you've had recent exposure to HIV, you need to be retested in a few months.

2. Voluntary Testing

Taking the HIV antibody test is voluntary, not required. If you want to withdraw your consent, you must do so within an hour after your blood is drawn for testing.

Anonymous testing sites are available where you can get counseling and testing without giving your name and address.

3. Confidentiality of Test Results

HIV test results are confidential and can only be released with your consent, or otherwise as permitted by state law.

Name (please print): _____

Informed Consent to Test for HIV

I have been advised of the medical reasons for performing this test, and the behaviors that are known to pose a risk for transmission of HIV. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I authorize Alliance Employee Health to perform an HIV antibody test on me, or the above patient for whom I am legal guardian.

_____ _____

Signature of person to be tested (or guardian, if appropriate) **Date**

Health Alliance™
Alliance Employee Health
Phone 513-585-6600
Fax 513-585-6525

INFORMED CONSENT TO TEST FOR HUMAN IMMUNODEFICIENCY VIRUS

1. What is the HIV Antibody Test?

Detecting HIV involves testing blood for antibodies to the human immunodeficiency virus—the virus that causes AIDS. If testing finds these antibodies, a series of various tests will then be done on the same blood sample to make sure the results of the first test were accurate. In some cases, further testing even beyond that may be required to confirm the diagnosis.

What does this mean to you? A positive test result means that you have been infected with the AIDS virus, but it does not mean you have AIDS. If you test positive, it's very important that you learn what treatment is available and how to avoid infecting others.

A negative test result means that you are probably not infected with the AIDS virus; however, it takes time for the body to produce these telltale antibodies. If you've had recent exposure to HIV, you need to be retested in a few months.

2. Voluntary Testing

Taking the HIV antibody test is voluntary, not required. If you want to withdraw your consent, you must do so within an hour after your blood is drawn for testing.

Anonymous testing sites are available where you can get counseling and testing without giving your name and address.

3. Confidentiality of Test Results

HIV test results are confidential and can only be released with your consent, or otherwise as permitted by state law.

Name (please print): _____

Informed Consent to Test for HIV

I have been advised of the medical reasons for performing this test, and the behaviors that are known to pose a risk for transmission of HIV. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I authorize Alliance Employee Health to perform an HIV antibody test on me, or the above patient for whom I am legal guardian.

_____ _____

Signature of person to be tested (or guardian, if appropriate) **Date**

Health Alliance™
Alliance Employee Health

Alliance Primary Care

Blood borne Pathogen Exposures

Report Blood borne pathogen exposures as soon as possible to the Employee Health Injury Line at 585-8000. After 4pm Monday through Friday, weekends and Holidays after dialing 585-8000 you will need to choose option "2" to be connected to a nurse.

The Injury Line nurse will give you directions on protocol to follow and answer any questions you may have regarding the exposure

It is important not to allow the patient to leave the facility in case lab work needs to be drawn on the patient.

Diagnostics®

11001058-5 8661636-7

EMPLOYEE HEALTH - ALLIANCE
3200 BURNET AVE BLDG A
CINCINNATI, OH 45229-3019

513-585-8000

☐ MY ACCOUNT
☐ PATIENT
☐ MEDICARE
☐ RAILROAD MEDICARE
☐ MEDICAID
☐ LabCard/Select
☐ OTHER INSURANCE

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SEX

PATIENT SOCIAL SECURITY # | OFFICE / PATIENT ID #

ROOM # | LAB REFERENCE # | PATIENT PHONE # ( )

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

CITY | STATE | ZIP

DID YOU REMEMBER...
TO INCLUDE DIAGNOSIS CODE(S)?
TO REQUEST OR MARK TEST(S)?
TO PROVIDE ORDER CODE(S) FOR HANDWRITTEN TESTS?
TO CHECK "BILL TO" BOX ABOVE?

E COLLECTED | TIME : ☐ AM ☐ PM | TOTAL VOL/HRS. ____ ML ____ HR | ☐ Fasting ☐ Non Fasting

I/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

( ) I04462 BOYD,KELLIE L

Source / Patient

INSURANCE

Primary Insurance ☐ Medicare ☐ Medicaid ☐ Other

Insurance Company Name

Insurance Member ID # | Group #

Insurance Address

Employer Name | Medicare/Medicaid #

Patient Is: ☐ Subscriber ☐ Spouse ☐ Other Dependent

Secondary Insurance ☐ Medicare ☐ Medicaid ☐ Other

Insurance Company Name

Insurance Member ID # | Group #

Insurance Address

Employer Name | Medicare/Medicaid #

Patient Is: ☐ Subscriber ☐ Spouse ☐ Other Dependent

ADDIT'L PHYS.: Dr. | NPI/UPIN

ON-PHYSICIAN PROVIDER: NAME | I.D.#

Fax Results to: ( )

d Client # OR NAME:
plicate ADDRESS:
port to: CITY: STATE ZIP

Medicare Limited Coverage Tests
@ = May not be covered for the reported diagnosis.
F = Has prescribed frequency rules for coverage.
& = A test or service performed with research/experimental kit.
B = Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary

ICD9 CODE(S) FOR DIAGNOSIS, SYMPTOM OR COMPLAINT (MUST BE PROVIDED)

RGAN / DISEASE PANELS

34392 ☐ **ELECTROLYTE PANEL** (Na, K, Cl, CO2) S
10256 ☐ **HEPATIC FUNCTION PANEL** (Alb, TBili, DBili, AP, AST, ALT, TP) S
10165 ☐ **BASIC METABOLIC PANEL w/eGFR** (Na, K, Ca, Cl, CO2, Glu, BUN, Cr) S
10231 ☐ **COMP METABOLIC PANEL w/eGFR** (Na, K, Cl, CO2, Glu, BUN, Cr, Ca, TP, Alb, TBili, AP, AST, ALT) S
7600 ☐ **LIPID PANEL** (Fasting Specimen) (TChol, Trig, HDL, calc. LDL) S
14852 ☐ **LIPID PANEL W/REFLEX DLDL** (TChol, Trig, HDL, calc. LDL or DLDL when Trig > 400) S
20210 ☐ **OBSTETRIC PANEL W/REFLEX** (ABO/Rh, Antibody Scr RBC w/reflex, CBC, RPR (DX) w/reflex confirm, HBsAg w/reflex confirm, Rubella IgG Ab) 2L,S
10306 ☐ **HEPATITIS PANEL, ACUTE W/REFLEX** (HBsAg w/reflex confirm, HC Ab, HA Ab IgM, HBcAb IgM) S

HEMATOLOGY

@ 510 ☐ HEMOGLOBIN L
@ 509 ☐ HEMATOCRIT L
@ 1759 ☐ CBC (H/H, RBC, Indices, WBC, PLT) L
@ 6399 ☐ CBC w/DIFF (H/H, RBC, Indices, WBC, PLT, DIFF) L
B 8847 ☐ PT WITH INR B
@ 763 ☐ PTT, ACTIVATED B

OTHER TESTS

7788 ☐ ABO GROUP & RH TYPE L
223 ☐ ALBUMIN (Alb) S
234 ☐ ALKALINE PHOSPHATASE (AP) S
823 ☐ ALT (SGPT) S
795 ☐ ANTIBODY SCR, RBC W/REFLEX ID L
822 ☐ AST (SGOT) S
285 ☐ BILIRUBIN, DIRECT (DBili) S
287 ☐ BILIRUBIN, TOTAL (TBili) S
303 ☐ CALCIUM (Ca) S
310 ☐ CARBON DIOXIDE (CO2) S
@ 10124 ☐ CARDIO CRP S
330 ☐ CHLORIDE (Cl) S

B 334 ☐ CHOLESTEROL, TOTAL (TChol) S
375 ☐ CREATININE (Cr) w/eGFR S
@ 395 ☐ CULTURE, URINE, ROUTINE*
B 8293 ☐ DIRECT LDL S
B 482 ☐ GGT S
B 483 ☐ GLUCOSE, SERUM (Glu) S
B 608 ☐ HDL S
512 ☐ HEP A AB IGM S
4848 ☐ HEP B CORE IGM AB S
499 ☐ HEP B SURFACE AB QUAL S
498 ☐ HEP B SURFACE AG W/REFLEX CONFIRM S
8472 ☐ HEP C VIRUS AB S
@ 7573 ☐ IRON (TOT), IBC, % SAT S
@ 571 ☐ IRON, TOTAL S
593 ☐ LDH S
622 ☐ MAGNESIUM S
OCC BLD, FECES - GUAIAC
B 35301 ☐ DX F 35306 ☐ MCR SCR
OCC BLD, FECES - FIT, InSure®
11290 ☐ DX F 11293 ☐ MCR SCR
718 ☐ PHOSPHORUS S

733 ☐ POTASSIUM (K) S
754 ☐ PROTEIN, TOTAL (TP) S
B 5363 ☐ PSA, TOTAL S
799 ☐ RPR (MONITORING) W/REFLEX TITER S
36126 ☐ RPR (DX) W/REFLEX CONFIRM FTA S
802 ☐ RUBELLA IGG AB S
836 ☐ SODIUM (Na) S
B 896 ☐ TRIGLYCERIDES (Trig) S
B 899 ☐ TSH S
B 36127 ☐ TSH W/REFLEX T-4, FREE S
859 ☐ T-3, TOTAL S
B 861 ☐ T-3 UPTAKE S
B 867 ☐ T-4 (THYROXINE), TOTAL S
B 866 ☐ T-4 (THYROXINE), FREE S
6448 ☐ UA, DIPSTICK ONLY U
7909 ☐ UA, DIPSTICK, W/REFLEX TO MICROSCOPIC U
5463 ☐ UA, COMPLETE (DIPSTICK & MICROSCOPIC) U
@ 3020 ☐ UA, COMPLETE, REFLEX TO CULTURE*
294 ☐ UREA NITROGEN (BUN) S
905 ☐ URIC ACID S

312431 X CP 312431
@312432 ☐ CP 312432
243 ☐ AMYLASE
8435 ☐ HCG, TOTAL, QL
@8396 ☐ HCG, TOTAL, QN
@34024 ☐ HCV RNA BY PCR, QL
@35645 ☐ HCV RNA, PCR, QUANT
501 ☐ HEP B CORE AB, TOTAL
8475 ☐ HEP B SURFACE AB QN
@37694 ☐ HIV 1/2 REFL WB
@34205 ☐ HIV-1 RNA, QUANT PCR
@19728 X HIV1/2 AB SCR W/RFLS
8599 ☐ LEAD, BLOOD
34256 ☐ MEASLES AB IGM, IF
964 ☐ MEASLES IGG AB
36565 ☐ MUMPS VIRUS AB (IGM)
8624 ☐ MUMPS VIRUS IGG, EIA
10314 ☐ RENAL PANEL W/EGFR
37675 ☐ RUBELLA AB IGG, IGM
8683 ☐ VARICELLA ZOSTER IGM
4439 ☐ VZV IGG AB
948 ☐ ZINC PROTOPORPHYR
SOURCE:
4550 ☐ CULTURE, AEROBIC E
4482 ☐ CULTURE, NP/NASAL
4556 ☐ CULTURE, SPUTUM
2692 ☐ HSV CULT
8801 ☐ SCREEN FOR S. AURE

ITIONAL TESTS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE. REFER TO DIRECTORY OF SERVICES.)

* Additional charge for ID/Susceptibility studies. Reflex tests are performed at an additional charge.

MMENTS, CLINICAL INFORMATION:

TOTAL TESTS ORDERED

ysician Signature (Required for PA, NY, NJ & MA)

For any patient of any payor (including Medicare and Medicaid) that has a medical necessity requirement, you should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

11001058 8661636

11001058 8661636

11001058 8661636

NAME: _____ 11001058 8661636

11001058 8661636

Diagnostics®

11001058-5 8661584-1

EMPLOYEE HEALTH - ALLIANCE
3200 BURNET AVE BLDG A
CINCINNATI, OH 45229-3019

513-585-8000

☐ MY ACCOUNT
☐ PATIENT
☐ MEDICARE
☐ RAILROAD MEDICARE
☐ MEDICAID
☐ LabCard/Select
☐ OTHER INSURANCE

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SE

PATIENT SOCIAL SECURITY # | OFFICE / PATIENT ID #

ROOM # | LAB REFERENCE # | PATIENT PHONE # ( )

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

CITY | STATE | ZIP

DID YOU REMEMBER...

TO INCLUDE DIAGNOSIS CODE(S)?

TO REQUEST OR MARK TEST(S)?

TO PROVIDE ORDER CODE(S) FOR HANDWRITTEN TESTS?

TO CHECK "BILL TO" BOX ABOVE?

TE COLLECTED | TIME : ☐ AM ☐ PM | TOTAL VOL/HRS. ____ ML ____ HR | ☐ Fasting ☐ Non Fasting

I/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

( ) I04462 BOYD,KELLIE L

Employee

ADDIT'L PHYS.: Dr. NPI/UPIN

ON-PHYSICIAN PROVIDER: NAME | I.D.#

Fax Results to: ( )

nd Client # OR NAME:

olicate ADDRESS:

port to: CITY: STATE ZIP

INSURANCE

Primary Insurance ☐ Medicare ☐ Medicaid ☐ Other

Insurance Company Name

Insurance Member ID # Group #

Insurance Address

Employer Name Medicare/Medicaid #

Patient Is: ☐ Subscriber ☐ Spouse ☐ Other Dependen

Secondary Insurance ☐ Medicare ☐ Medicaid ☐ Other

Insurance Company Name

Insurance Member ID # Group #

Insurance Address

Employer Name Medicare/Medicaid #

Patient Is: ☐ Subscriber ☐ Spouse ☐ Other Dependen

Medicare Limited Coverage Tests

@= May not be covered for the reported diagnosis.
F = Has prescribed frequency rules for coverage.
& = A test or service performed with research/experimental kit.
B = Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary

ICD9 CODE(S) FOR DIAGNOSIS, SYMPTOM OR COMPLAINT (MUST BE PROVIDED

ORGAN / DISEASE PANELS

34392 ☐ **ELECTROLYTE PANEL** (Na, K, Cl, CO2) S

10256 ☐ **HEPATIC FUNCTION PANEL** (Alb,TBili, DBili, AP, AST, ALT, TP) S

10165 ☐ **BASIC METABOLIC PANEL w/eGFR** (Na, K, Ca, Cl, CO2, Glu, BUN, Cr) S

10231 ☐ **COMP METABOLIC PANEL w/eGFR** (Na, K, Cl, CO2, Glu, BUN, Cr, Ca, TP, Alb, TBili, AP, AST, ALT) S

3 7600 ☐ **LIPID PANEL** (Fasting Specimen) (TChol, Trig, HDL, calc. LDL) S

14852 ☐ **LIPID PANEL W/REFLEX DLDL** (TChol, Trig, HDL, calc. LDL or DLDL when Trig > 400) S

20210 ☐ **OBSTETRIC PANEL W/REFLEX** (ABO/Rh, Antibody Scr RBC w/reflex, CBC, RPR (DX) w/reflex confirm, HBsAg w/reflex confirm, Rubella IgG Ab) 2L,S

10306 ☐ **HEPATITIS PANEL, ACUTE W/REFLEX** (HBsAg w/reflex confirm, HC Ab, HA Ab IgM, HBcAb IgM) S

HEMATOLOGY

@ 510 ☐ HEMOGLOBIN L
@ 509 ☐ HEMATOCRIT L
@ 1759 ☐ CBC (H/H, RBC, Indices, WBC, PLT) L
@ 6399 ☐ CBC w/DIFF (H/H, RBC, Indices, WBC, PLT, DIFF) L
B 8847 ☐ PT WITH INR B
@ 763 ☐ PTT, ACTIVATED B

OTHER TESTS

7788 ☐ ABO GROUP & RH TYPE L
223 ☐ ALBUMIN (Alb) S
234 ☐ ALKALINE PHOSPHATASE (AP) S
823 ☐ ALT (SGPT) S
795 ☐ ANTIBODY SCR, RBC W/REFLEX ID L
822 ☐ AST (SGOT) S
285 ☐ BILIRUBIN, DIRECT (DBili) S
287 ☐ BILIRUBIN, TOTAL (TBili) S
303 ☐ CALCIUM (Ca) S
310 ☐ CARBON DIOXIDE (CO2) S
@ 10124 ☐ CARDIO CRP S
330 ☐ CHLORIDE (Cl) S

B 334 ☐ CHOLESTEROL, TOTAL (TChol) S
375 ☐ CREATININE (Cr) w/eGFR S
@ 395 ☐ CULTURE, URINE, ROUTINE*
B 8293 ☐ DIRECT LDL S
B 482 ☐ GGT S
B 483 ☐ GLUCOSE, SERUM (Glu) S
B 608 ☐ HDL S
512 ☐ HEP A AB IGM S
4848 ☐ HEP B CORE IGM AB S
499 ☐ HEP B SURFACE AB QUAL S
498 ☐ HEP B SURFACE AG W/REFLEX CONFIRM S
8472 ☐ HEP C VIRUS AB S
@ 7573 ☐ IRON (TOT), IBC, % SAT S
@ 571 ☐ IRON, TOTAL S
593 ☐ LDH S
622 ☐ MAGNESIUM S
OCC BLD, FECES - GUAIAC
B 35301 ☐ DX F 35306 ☐ MCR SCR
OCC BLD, FECES - FIT, InSure®
11290 ☐ DX F 11293 ☐ MCR SCR
718 ☐ PHOSPHORUS S

733 ☐ POTASSIUM (K) S
754 ☐ PROTEIN, TOTAL (TP) S
B 5363 ☐ PSA, TOTAL S
799 ☐ RPR (MONITORING) W/REFLEX TITER S
36126 ☐ RPR (DX) W/REFLEX CONFIRM FTA S
802 ☐ RUBELLA IGG AB S
836 ☐ SODIUM (Na) S
B 896 ☐ TRIGLYCERIDES (Trig) S
B 899 ☐ TSH S
B 36127 ☐ TSH W/REFLEX T-4, FREE S
859 ☐ T-3, TOTAL S
B 861 ☐ T-3 UPTAKE S
B 867 ☐ T-4 (THYROXINE), TOTAL S
B 866 ☐ T-4 (THYROXINE), FREE S
6448 ☐ UA, DIPSTICK ONLY U
7909 ☐ UA, DIPSTICK, W/REFLEX TO MICROSCOPIC U
5463 ☐ UA, COMPLETE (DIPSTICK & MICROSCOPIC) U
@ 3020 ☐ UA, COMPLETE, REFLEX TO CULTURE*
294 ☐ UREA NITROGEN (BUN) S
905 ☐ URIC ACID S

312431 CP 312431
@312432 X CP 312432
243 AMYLASE
8435 HCG, TOTAL, QL
88396 HCG, TOTAL, QN
834024 HCV RNA BY PCR, QL
835645 HCV RNA, PCR, QUANT

501 HEP B CORE AB, TOTAL
8475 HEP B SURFACE AB QN
837694 HIV 1/2 REFL WB
834205 HIV-1 RNA, QUANT PCR
@19728 X HIV1/2 AB SCR W/RFLS
8599 LEAD, BLOOD
34256 MEASLES AB IGM, IF

964 MEASLES IGG AB
36565 MUMPS VIRUS AB (IGM)
8624 MUMPS VIRUS IGG, EIA
10314 RENAL PANEL W/EGFR
37673 RUBELLA AB IGG, IGM
8683 VARICELLA ZOSTER IGM
4439 VZV IGG AB

948 ZINC PROTOPORPHYRI
SOURCE:
4550 CULTURE, AEROBIC &
4462 CULTURE, NP/NASAL
4556 CULTURE, SPUTUM
2692 HSV CULT
8001 SCREEN FOR S. AURE

ITIONAL TESTS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE. REFER TO DIRECTORY OF SERVICES.)

* Additional charge for ID/Susceptibility studies.
Reflex tests are performed at an additional charge.

MMENTS, CLINICAL INFORMATION:

TOTAL TESTS ORDERED

ysician Signature (Required for PA, NY, NJ & MA)

For any patient of any payor (including Medicare and Medicaid) that has a medical necessity requirement, you should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

11001058 11001058
11001058 8661584 8661584
8661584
NAME: _____ 11001058 11001058
8661584 8661584

CINCINNATI CLINICAL LAB REQUISITION

LabOne
now a part of Quest Diagnostics
6700 Steger Drive • Cincinnati, OH 45237-3046
513-353-6000 • 1-800-837-2520

PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Source / Patient

EVANS, JOHN N.

EMPLOYEE HEALTH - ALLIANCE
ALLIANCE BUSINESS CENT-A LEVEL
CINCINNATI, OH
45229
585-8000

☐ FASTING ☐ STAT ☐ ABN Submitted ☐ Frozen Sample Sent Separately

PATIENT INFORMATION (PLEASE PRINT)

ast Name | First | MI

atient Phone No. ( ) — | SEX: M ☐ F ☐ | DOB / / | Chart No.

ocial Security — — | Ordering Physician (full name)

atient Street Address _____ Apt.# _____

ity: _____ State: _____ Zip: _____

larital Status: (Circle one) S M W D

GUARANTOR INFORMATION

uarantor Name (required if patient < 18 years old & unmarried):

uarantor Relationship to patient: ☐ Self ☐ Parent ☐ Other _____

uarantor Street Address: _____

ity: State: Zip:

NOTIFICATION OF RESULTS

] Fax To My Office ☐ Call To: _____ ☐ Addtl. Copy To: _____

treet: City: State: Zip:

COLLECTION INFORMATION

ollection Date: Time: Collector ID:

=SST L=LAVENDER B=BLUE P=PINK UG=URINE GRAY R=PLAIN RED

BILLING INFORMATION (PLEASE PRINT)

Please bill: ☐ Patient / Insurance ☐ My office account

For KENTUCKY MEDICAID, please provide PCP's KENPAC# : _____

Primary Insurance Name:

Subscriber ID: | Employer Name:

Group Number: | Subscriber Name:

Subscriber Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____ | Subscriber Date of Birth: / /

Insurance Street Address: _____

City: State: Zip:

Secondary Insurance Name:

Subscriber ID: | Employer Name:

Group Number: | Subscriber Name:

Subscriber Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____ | Subscriber Date of Birth: / /

Insurance Street Address: _____

City: State: Zip:

			ICD-9 CODE
SGPT	ALT (SGPT)	S	
ANA	ANA + titer if positive	S	
ABS	Antibody Scrn+ID	P	
SGOT	AST (SGOT)	S	
B12	B12	S	
BILI	Bili, Dir + Tot	S	
TBIL	Bilirubin, Total	S	
GPRH	Blood Type / RH	P	
BUN	Urea Nitrogen	S	
CBCD @	CBC + Plat + Diff	L	
CBC @	CBC + Plat w/o Diff	L	
CA	Calcium	S	
CHOL @	Cholesterol	S	
CREAT	Creatinine	S	
CRPHS	CRP High Sensitivity	S	
FOLATE	Folate	S	
GGT @	Gamma GT	S	
GLU @	Glucose	S	
GLYCO @	Hemoglobin A1C	L	
HH @	HGB + HCT	L	
HCG	HCG, Qualitative	S	
HCGQUANT @	HCG, Quantitative	S	
HBSAB	Hep B Surf Antibody	S	
HEPBSQN	Hep B Antibody Quant	S	
HBSAG	Hep B Surf Antgn	S	
HCVAB	Hep C Antibody	S	
HIVR @	HIV Antibody	S	
IS @	Iron & TIBC	S	

= Tests where ABN may be required.
= ID / Sensitivity / Confirm at additional charge

			ICD-9 CODE
○ LDH	LDH	S	
○ OCCULT @	Occult Blood (Diagnostic)		
○ OCCSCR @	Occult Blood (SCREEN)		
○ K	Potassium	S	
○ PHOS	Phosphorus	S	
○ PSAD @	PSA (Diagnostic)	S	
○ PSASCR @	PSA (SCREEN)	S	V76.44
○ PE	Prot Elect(+Ig's+IFE Reflex)	S	
○ PT @	Protime	B	
○ RF	Rheumatoid Fctr	S	
○ SYPHILS @	Syphilis IgG (T. pallidum)	S	
○ RUB	Rubella	S	
○ ESR	Sediment Rate	L	
○ NA	Sodium	S	
○ T4 @	T4	S	
○ FT4 @	T4, Free	S	
○ TSH @	TSH	S	
○ TSHRFX @	TSH + FT4 Reflex	S	
○ TGL @	Triglycerides	S	
○ UA	Urinalysis	UG	
○ URC	Uric Acid	S	
Other _____			

CPT ORGAN OR DISEASE PANELS

			ICD-9 CODE
○ HEPACU	Acute Hepatitis	S	
○ EP1	Basic Metabolic	S	
○ METAPNL	Comp. Metabolic	S	
○ EP	Electrolytes	S	
○ FATS @	Lipid Panel	S	
○ Kidney @	Renal Function	S	
○ LIVP @	Hepatic Funct	S	
○ OB	OB Panel*	SLP	

Microbiology

ICD-9 CODE

○ No Gram Stain ○ No Sensitivity

BODY SITE _____

○ ANAC	Anaerobic Culture*	
○ BODFC	Body Fluid Culture* + Gram Stain	
○ CDT	Clostridium Difficile Toxin	
○ DNAP	DNA Probe GC & Chlamydia	
○ DNACH	DNA Probe Chlamydia	
○ DNAGC	DNA Probe GC	
○ EYEC	Eye Culture* + Gram Stain	
○ FC	Fungus Culture* + Stain if needed	
○ GENC	Genital Culture*	
○ GCC	G.C. Culture*	
○ HSVC	Herpes Simplex Virus Culture	
○ HPV	Human Papilloma Virus	
○ HPVH	Human Papilloma Virus, High Risk	
○ RC	Misc Culture* + Gram Stain	
○ SAS	MRSA Staph Aureus Culture*	
○ RFA	Rapid Flu A + Viral Culture if Neg*	
	○ No viral culture if Neg	
○ RVC	Resp. Viral Cult*	
○ NP	Nasopharyngeal Culture *	
○ GIACRYAG	Parasites: Giardia/Crypto AG only	
○ ROTAVIR	Rotavirus	
○ SC	Sputum Culture* + Gram Stain	
○ SADP	Strep A Direct Probe	
○ SBDP	Strep B Direct Probe (Vag)	
○ STC	Stool Culture* (Salm, Shig, Campy)	
○ STEC	Stool (E. coli, Shiga Toxin)	
○ THC	Throat Culture*	
○ HZVC	Varicella Zoster Virus	
○ UC @	Urine culture* cc: _____ cath: _____	

ICD9	(X)	TESTCODE	TESTNAME	/TUBETYPE
	( )	VZV	VZV IGG AB	/
	( )	MUMPIGG	MUMPS IGG AB	/
	( )	RUBIGG	RUBEOLA IGG	/
	( )	LEADPN	INDUST LEAD	/
	(X)	OCCEXP	OCC EXP SCRE	/
	( )	ANY	ANYLAST	
	( )	HIVR	HIV-1/HIV-2	/S
	( )	NDSTKII	NDSTKII	/S
	( )	NDSTKI	NDSTKI	/S

Health Alliance™

Alliance Business Center
3200 Burnet Avenue, A Level
Cincinnati, OH 45229

Alliance Employee Health Injury Line
Injury Line Phone 513-585-8000
Injury Line Fax 513-585-6525

Associate Accident Report

Workplace location:

- ☐ St. Luke Hospital East
- ☐ St. Luke Hospital West
- ☐ The Jewish Hospital
- ☐ The Fort Hamilton Hospital
- ☐ Alliance/ABC
- ☐ Alliance Primary Care
- ☐ **AGENCY**
- ☐ The Christ Hospital
- ☐ The University Hospital
- ☐ **OTHER**

Occupational injury, exposure, or disease (to be completed by Health Alliance associate)			
Last Name, First Name, Middle Initial		Home Phone #	Social Security Number
Home Address		Job Title	Date of Birth
City	State	9-digit Zip Code	Date Hired
Department/Dept. phone #	Supervisor's name		Supervisor's phone #
Associate usually works on: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat		Regular work hours: From _____ to _____	☐ Male ☐ Female
Date of injury/exposure/onset of illness. etc.	Time of injury: _____ ☐ am ☐ pm	Describe incident ***in detail:*** (e.g., specify approximate weight/size of any object involved; name any substance involved...oil/water...etc.; did associate trip or fall, etc., as appropriate)	
Specify exact nature of injury and part of body affected (e.g., "fracture of right hand," etc.)			
Where was initial care received? ☐ Alliance Employee Health ☐ Emergency Department ☐ OccNet (location): _____ ☐ Other (specify): _____			
Did injury or exposure happen on the employer's premises? ☐ Yes ☐ No			
Accident Location (street address)			Date Employer Notified
City	State	Zip Code	State Where Employed

Medical Release

I understand that I am allowing any provider that attends to, treats, or examines me to release all medical, psychological, and/or psychiatric information that is related to my injury to my employer, and my employer's representative and Third Party Administrator.

Signing this report ***does not*** constitute certification of a Worker's Compensation claim.

Associate's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Send white copy to Alliance Employee Health ⊙ Send yellow copy to manager