



# Specimens:	
Collect Date:	Time: By:
MR #:	A #:

**REQUIRED (PRINT OR PATIENT LABEL)**

Name (Last, First, MI)	
Date of Birth	Sex: (circle) M F
Street Address	
Street Address 2	
City, State, Zip	
Phone Number	Client Number

please enter the name and address of the office the samples came from below

**[PA]**

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**BILL TO (even if IDX sticker attached):**

Bill to Kidney Acquisition Fund  
Alt Ins: KA - Kidney Acquisition

(ZDM1A) Zand, Martin MD

Phone Results to: \_\_\_\_\_ Fax Results to: \_\_\_\_\_

Ordering Provider's Signature \_\_\_\_\_  
Date of Signature N/A

Diagnosis Mandatory: Signs/Symptoms or ICD9 Codes  
*If ordered for screening, list test name here and write "SCREENING" after it* N/A

Send Additional Reports To: (Full Name/Address) N/A

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-9 code(s) or a descriptive diagnosis must be included on each patient for each test ordered. It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

**TISSUE TYPING**

HLAR  HLA (Tissue Typing)  
Hold Red