

# Machaon Diagnostics

## ADAMTS-13 Test Drawing Kit Form

Please use our standard order form for inpatient test requests  
(available online or by fax)

Medical Director: Brad H. Lewis, MD  
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www.MachaonDiagnostics.com  
1-800-566-3462

PATIENT INFORMATION (complete or attach)			CLINICAL PRESENTATION	
Patient's Name: (Last, First, M.I.)		Gender: <input type="checkbox"/> (M) or <input type="checkbox"/> (F)	<input type="checkbox"/> Thrombotic Microangiopathy (TMA), unspecified	
Specimen Date: (MM/DD/YYYY)		Date of Birth: (MM/DD/YYYY)	<input type="checkbox"/> Thrombotic Thrombocytopenic Purpura (TTP)	
Collection Time: (AM) (PM)		Patient's Social Security #:	<input type="checkbox"/> Hemolytic Uremic Syndrome (HUS)	
Patient's Address:		Patient's Phone Number:	<input type="checkbox"/> Shiga toxin-related HUS	
Patient's City:		State:	Zip Code:	<input type="checkbox"/> Atypical HUS (aHUS)
Guardian's name: (if patient is under 18)		Guardian's Phone Number:		
		<input type="checkbox"/> Other: _____ (please provide)		
ORDERING PHYSICIAN INFORMATION			OTHER INFORMATION (if available)	
Physician's Name: (Last, First, M.I.)		Physician's NPI:		
Contact Phone Number:		Fax Number for Results:		
LDH: _____ (U/L)		Creatinine: _____ (mg/dL)		
Platelet Count: _____ (K/ $\mu$ L)		Last Plasma Infusion Date: (MM/DD/YYYY)		
Hemoglobin: _____ (mg/dL)				
Phone number(s) to call with STAT results: (test resulted within 24 hrs)				
INSURANCE INFORMATION (complete or attach)			TEST SELECTION	
Insurance Company: (Medicare patients must sign ABN on reverse)			<input type="checkbox"/> ADAMTS-13 Activity (ELISA) <small>Reflexes to Inhibitor</small>	
Insurance Policy Number:		Insurance Group Number:		
Insurance Company Address:		Authorization Number:		
Insurance Company City:		State:	Zip Code:	<input type="checkbox"/> ADAMTS-13 Inhibitor (ELISA)
DIAGNOSIS CODE(S):			BILLING POLICY / PATIENT SIGNATURE	
ICD-9 Code:	ICD-9 Code:	ICD-9 Code:	Machaon Diagnostics may need to obtain additional information from your physician to complete these services. I hereby authorize the release of medical information related to the services described herein and authorize payment directly to Machaon Diagnostics. Machaon Diagnostics is a PARTICIPATING PROVIDER of Medicare only. The ADAMTS-13 Activity test is \$248 and if indicated, the inhibitor test is \$530. I agree to assume responsibility for payment of charges for services that are not covered by my healthcare insurer.	
Patient's Signature:			Date: _____	
X: _____				
SPECIMEN COLLECTION, PROCESSING AND SHIPPING				
Specimen Collection and Processing			Specimen Shipping	
1. Draw 1 blue top tube (3.2% sodium citrate).			6. Place all forms into document sleeve of the biohazard bag.	
2. Spin tube for cell-free plasma (approx. 15 minutes at 2000 x g).			7. Ensure that no patient-specific information is visible.	
3. Transfer approximately 1mL into the provided sample tube.			8. Place biohazard bag into the provided FedEx Clinical Pak.	
4. Label tube with patient first and last name, draw date and DOB.			9. Complete the provided FedEx Airbill and affix Airbill pouch to Pak.	
5. Enclose tube in Styrofoam box and seal in biohazard bag.			10. Call FedEx 800-238-5355 for a pick-up. (Monday-Thursdays ONLY)	
ADDITIONAL INFORMATION				
Machaon Diagnostics is a California-licensed, CLIA-accredited, CAP-accredited, clinical laboratory approved to provide high-complexity testing services. Machaon Diagnostics is a PARTICIPATING PROVIDER of Medicare. Patients with insurance coverage other than Medicare are considered out-of-network and will be billed for services not covered by their insurance provider. Medicare patients must sign an ABN, either located on the reverse side of this form or downloaded from the Machaon Diagnostics website. Patient insurance billing services are provided in accordance with the Machaon Insurance Billing Policy. HMO or medical group covered patients may need a prior authorization if they seek reimbursement.				

Patient Name:

Identification Number:

## ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare does not pay for the checked items below, you may have to pay. Medicare does not pay for everything, including laboratory testing that your healthcare provider has good reason to think you need. We expect Medicare not to pay for the tests checked below.

<b>Check Ordered Tests:</b>	<p><b>*See reasons (1.) and (2.) below.</b></p> <p><input checked="" type="checkbox"/> ADAMTS-13 Activity (\$248) [85397]</p> <p><input checked="" type="checkbox"/> ADAMTS-13 Inhib (\$530) [85397, 85335]</p> <p><input type="checkbox"/> Anticardiolipin Antibody (\$333)</p> <p><input type="checkbox"/> Antithrombin III (\$165)</p> <p><input type="checkbox"/> Ecarin Clotting Time (\$241)</p> <p><input type="checkbox"/> Euglobulin Clot Lysis (\$198)</p> <p><input type="checkbox"/> Factor II Mutation (\$327)</p> <p><input type="checkbox"/> Factor V Mutation (\$327)</p> <p><input type="checkbox"/> Factor VIII Activity (\$130)</p> <p><input type="checkbox"/> Factor IX Activity (\$130)</p> <p><input type="checkbox"/> Fibrinogen (\$60)</p> <p><input type="checkbox"/> Fondaparinux Level (\$247)</p> <p><input type="checkbox"/> Heparin Antibody (\$655)</p> <p><input type="checkbox"/> Heparin Level (\$247)</p> <p><input type="checkbox"/> Inhibitor Screen (\$490)</p> <p><input type="checkbox"/> Inhibitor Titer (\$685)</p> <p><input type="checkbox"/> Lupus Anticoagulant Index (\$168)</p> <p><input type="checkbox"/> Mixing Studies - aPTT (\$253)</p> <p><input type="checkbox"/> Mixing Studies - PT (\$182)</p>	<p><input type="checkbox"/> MTHFR (C677T) (\$327)</p> <p><input type="checkbox"/> MTHFR (A1298C) (\$327)</p> <p><input type="checkbox"/> Platelet Aggregation (\$1,485)</p> <p><input type="checkbox"/> Platelet Antibodies (\$462)</p> <p><input type="checkbox"/> Plavix / Plasugrel LTA (\$540)</p> <p><input type="checkbox"/> Protein C (\$161)</p> <p><input type="checkbox"/> Protein S (\$213)</p> <p><input type="checkbox"/> PT/INR (\$98)</p> <p><input type="checkbox"/> PTT (\$84)</p> <p><input type="checkbox"/> Ristocetin-induced LTA (\$540)</p> <p><input type="checkbox"/> RVVT (\$150)</p> <p><input type="checkbox"/> TCT (\$79)</p> <p><input type="checkbox"/> TCT/PS (\$79)</p> <p><input type="checkbox"/> Venous blood draw (\$35)</p> <p><input type="checkbox"/> vWF Antigen (\$109)</p> <p><input type="checkbox"/> vWF Activity (\$198)</p> <p><input type="checkbox"/> vWF Multimer (\$300)</p> <p><input type="checkbox"/> vWF Profile (\$521)</p> <p><b>List other tests here:</b></p>	<p><b>*See reason (3.) below.</b></p> <p><input type="checkbox"/> Warfarin Genotype (\$681)</p> <p><input type="checkbox"/> Plavix / Plasugrel Genotype (\$431)</p> <p><b>List other tests here:</b></p> <p><b>*Please visit <a href="http://www.dot.md">www.dot.md</a> to view test CPT code(s) and units.</b></p>
<b>Reason Medicare May Not Pay:</b>	<ol style="list-style-type: none"> <li>1. Medicare does not pay for these tests for your condition.</li> <li>2. Medicare does not pay for these tests as often as this (denied as too frequent).</li> <li>3. Medicare does not pay for experimental or research use tests.</li> </ol>		
<b>Estimated Cost:</b>	\$		

**What you need to know:**

- Read this notice so that you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the tests checked above.

**Note:** If you choose Option 1 or 2, we may help you use any other insurance that you may have, but Medicare cannot require us to do this.

<b>OPTIONS:</b> Check only one box. We cannot choose a box for you.
<input type="checkbox"/> <b>OPTION 1.</b> I want the tests listed above. I may be asked to pay now, but I also want Medicare billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but <b>I can appeal to Medicare</b> by following the directions on the MSN. If Medicare does pay, I will be refunded any payments I made to Machaon Diagnostics, less co-pays or deductibles.
<input type="checkbox"/> <b>OPTION 2.</b> I want the tests listed above, but do not bill Medicare. I may be asked to pay now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b>
<input type="checkbox"/> <b>OPTION 3.</b> I do not want the tests listed above. I understand with this choice <b>I am not responsible for payment</b> , and I cannot appeal to see if Medicare would pay.

**This notice gives your opinion, not an official Medicare decision.** If you have questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understood this notice. You will also receive a copy.

<b>Signature:</b>	<b>Date:</b>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.