LYME DISEASE TEST REQUEST

Stony Brook Medicine

Stony Brook, NY 11794

LYME DISEASE LABORATORY
STONY BROOK UNIVERSITY MEDICAL CENTER
101 NICOLLS RD
LEVEL 3 ROOM 508
STONY BROOK, NY 11794-7300

PHONE: 631-444-3824
FAX: 631-444-7526
BILLING CUSTOMER SERVICE: 631-444-4151

LAB USE ONLY

LYSS ☐ LYSF ☐
LYWS ☐ LYWF ☐
LYPR ☐ LYVC ☐
☐ REFLEX

VISIT OUR WEB SITE AT: WWW.MEDICINE.STONYBROOKMEDICINE.EDU/PATHOLOGY/TICK

PATIENT INFORMATION (ALL INFORMATION REQUIRED)

NAME (LAST, FIRST): | SEX: ❑ F ❑ M

STREET ADDRESS:

CITY: | STATE | ZIP

DATE OF BIRTH: | S. S. #:

PATIENT PHONE #: | PATIENT I.D. #:

DATE OF SERVICE (REQUIRED): | RACE/ETHNICITY:

REFERRING PHYSICIAN / LAB / HOSPITAL

NAME:

ADDRESS:

CITY: | STATE | ZIP:

PHONE: | FAX:

MD NPI #:

MD LICENSE #:

PLEASE TURN THIS PAGE OVER ➡

BILLING INFORMATION (REQUIRED)

PLEASE BILL: ❑ HOSPITAL ❑ LABORATORY ❑ PATIENT SELF PAY

INSURANCE: ❑ PRIVATE INSURANCE PLAN ❑ MEDICAID ❑ MEDICARE

READ BELOW AND SIGN ON BACK

IMPORTANT: IF THE PATIENT IS SUBMITTING INSURANCE OR IS SELF-PAY, THEPATIENT MUST READ THE "GUARANTEE OF PAYMENT" STATEMENT AND SIGN/DATE WHERE INDICATED ON THE BACK OF THIS PAGE IN ORDER TO BEGIN TESTING. A COPY OF THE PATIENT'S INSURANCE CARD BACK AND FRONT IS MANDATORY IN ORDER TO BILL PROPERLY.

INS. CO. NAME: | POLICY HOLDER: | POLICY HOLDER'S DATE OF BIRTH:

INS. CO. ADDRESS:
STREET / BOX TOWN STATE ZIP

POLICY #: | GROUP #: | EFFECTIVE DATE: FROM TO

To the ordering Physician: Physicians should only order tests for patients which are medically necessary for the diagnosis and treatment of each patient. Medicare will only pay for tests which meet the Medicare definition of "Medical Necessity". Payment may be denied for a test the physician believes is appropriate, but that does not meet the Medicare definition of medical necessity.

DIAGNOSIS CODES (ICD 10):

TESTS REQUESTED AND MINIMUM VOLUMES

SPECIMEN TYPE	A STONY BROOK ELISA (SEROLOGY, ANTIBODY TITER, SCREENING TEST, TOTAL ANTIBODY: IgG, IgA, IgM)	B STONY BROOK ELISA WITH REFLEX WESTERN BLOT (DO WB ONLY IF ELISA IS BORDERLINE OR POSITIVE)	C WESTERN BLOT IgM AND IgG (CONFIRMATORY, IMMUNOBLOT)	D LIST CDC NON-SPECIFIC BANDS ON THE WESTERN BLOT	E VLSE1/PEPC10 ZEUS WITH REFLEX WESTERN BLOT IgM AND IgG ANTIBODY
SERUM *	❑ (0.5 ml)	❑ (1.0 ml)	❑ (0.5 ml)	❑	
SPINAL FLUID* (CSF)	❑ (0.5 ml)	❑ (3.5 ml)	❑ (3.0 ml)		
CSF / SERUM PAIR*	❑ (1.0 ml each) INCLUDES INDEX	❑ CSF (3.5 ml) ❑ SERUM (1.0 ml)	❑ CSF (3.0 ml) ❑ SERUM (0.5 ml)	TICK ID ❑	❑ SERUM (0.5 ml)
JOINT FLUID*	❑ (0.5 ml)	❑ (1.0 ml)	❑ (0.5 ml)		

*Please note, if positive or equivocal, a confirmatory western blot will be performed and additional charges will be incurred.

*** SEE BACK OF THIS PAGE FOR SPECIMEN SHIPPING AND HANDLING REQUIREMENTS AND MANDATORY "GUARANTEE OF PAYMENT" SIGNATURE**

Ver. 04/20

SAMPLE TUBE, SPECIMEN, AND SHIPPING REQUIREMENTS

SPECIMEN TUBE LABELING

ALL SAMPLE TUBES MUST BE LABELED WITH:
1. THE PATIENT'S FULL NAME
2. THE PATIENT'S DATE OF BIRTH OR ANOTHER IDENTIFIER UNIQUE TO THE PATIENT (MEDICAL RECORD #, ID#, ETC.)

TUBES NOT LABELED ACCORDINGLY WILL NOT BE TESTED NOR WILL THEY BE RETURNED.

SPECIMEN REQUIREMENTS:

- OUR TESTING REQUIRES SERUM, CEREBRAL SPINAL FLUID (CSF), OR JOINT FLUID.
- ALL BLOOD SPECIMENS MUST BE SPUN DOWN AND THE SERUM SEPARATED FROM THE CLOT BEFORE TRANSPORTING TO OUR LAB.
- WHEN REMOVING THE SERUM SAMPLE INTO A "POUR-OFF" TUBE, A SCREW CAP WITH A LEAK PROOF SEAL IS RECOMMENDED.
- SERUM SEPARATOR TUBES (SST) CAN BE SHIPPED DIRECTLY ONCE THE TUBE HAS BEEN CENTRIFUGED AND THE SERUM HAS BEEN SEPARATED FROM THE CLOT.
- CSF AND JOINT FLUIDS CAN BE SENT IN ANY APPROVED STERILE SPECIMEN TUBE, PREFERABLY WITH A SCREW CAP.
- SPECIMENS CAN BE SHIPPED AT ROOM TEMPERATURE AS LONG AS THEY ARRIVE WITHIN TWO DAYS.
- TICKS CAN BE SHIPPED IN A "ZIP-LOCK" PLASTIC BAG IN A MAILING ENVELOPE. PLACE A MOIST PIECE OF PAPER TOWEL IN THE BAG FOR MOISTURE. PLEASE CALL THE LYME LAB BEFORE SHIPPING A TICK (631-444-3824). ADD PROTECTION TO PREVENT THE TICK FROM BEING CRUSHED IF NEEDED. PLEASE NOTE: THERE IS A FEE ASSOCIATED WITH TICK IDENTIFICATION.

SHIPPING METHODS

OUR LAB UTILIZES UPS FOR OUR RETURN SHIPPING. WE SUPPLY, FREE OF CHARGE, POSTAGE PAID, SELF ADDRESSED SHIPPING CONTAINERS AND BOXES WHICH WE CALL "KITS". YOU CAN REQUEST THESE KITS BY CALLING 631-444-3824. WE SUPPLY THESE KITS TO U.S. DOCTORS, LABS, AND MEDICAL INSTITUTIONS. PATIENTS MUST OBTAIN THESE KITS THROUGH ONE OF THESE ENTITIES. KITS ARE FOR THE SHIPMENT OF PATIENT SPECIMENS. WE DO NOT SUPPLY THE BLOOD DRAWING SUPPLIES, ONLY THE SHIPPING CONTAINERS.

SPECIMENS CAN BE SENT BY OTHER SHIPPING COMPANIES AS LONG AS THEY ARRIVE WITHIN TWO DAYS AND ARE SHIPPED IN AN APPROVED I.A.T.A. PACKAGE. PACKAGING MUST BE LABELED "BIOLOGICAL SUBSTANCE - CATEGORY B (UN 3373)". PACKAGING DOES NOT REQUIRE BIOHAZARD LABELS.

PLEASE VISIT OUR WEB SITE LISTED ON THE FRONT OF THIS FORM FOR CURRENT TEST PRICES AND CODES OR CALL 631-444-3824. PRICING IS SUBJECT TO CHANGE WITHOUT NOTICE.

GUARANTEE OF PAYMENT

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THE FOLLOWING:

MANY INSURANCE COMPANIES, INCLUDING MANAGED CARE ORGANIZATIONS, REQUIRE PRIOR WRITTEN AUTHORIZATION FOR CERTAIN BLOOD TESTS. IT IS YOUR RESPONSIBILITY AS A PATIENT TO OBTAIN ALL NECESSARY AUTHORIZATIONS FROM YOUR INSURANCE COMPANY PRIOR TO TESTING.

I ALSO AGREE TO PAY STONY BROOK UNIVERSITY MEDICAL CENTER, STONY BROOK, NY, ANY BALANCES RESULTING FROM THE NONPAYMENT AND/OR THE DENIAL OF INSURANCE CLAIMS, REPRESENTING THE BALANCE ON MY ACCOUNT.

I UNDERSTAND THAT I MAY BE HELD RESPONSIBLE FOR ANY COMMISSIONS PAID TO ATTORNEYS OR COLLECTION AGENCIES IF I DEFAULT ON MY PAYMENT ARRANGEMENTS AND THE HOSPITAL PLACES THE ACCOUNT WITH AN OUTSIDE SERVICE FOR COLLECTION.

PATIENT / GUARANTOR SIGNATURE:
DATE SIGNED:
WITNESS: