The following information must be provided on the test requisition. Please provide all necessary information to avoid fees being transferred to the patient.

Insurance—Third Party Billing

The patient's insurance company is billed directly only if the physician/client provides the necessary billing information on the requisition. Your office will be contacted if the following information is not provided:

- Patient name (last, first, middle)
- Patient date of birth
- Patient gender
- Patient current address (including city, state, and zip code)
- Patient current phone number (including area code)
- Patient Social Security number
- Patient relationship to insured
- Insurance carrier name
- Insurance carrier address (including city, state, and zip code)
- Subscriber name
- Member/insured identification number
- Member/insured group number
- Member/insured employer name
- Medicare/Medicaid number (if applicable)
- Requesting physician name
- Requesting physician Unique Physician Identifying Number (UPIN) or provider number
- Requesting physician National Provider Identifier (NPI) number
- ICD-10 diagnosis code (Documented from the patient's chart notes and to the highest level of specificity.)

Some insurance companies require a co-payment and/or deductible for which the patient is responsible. The Northwell Health Laboratories participates with a variety of insurance plans and managed care organizations Health Maintenance Organizations (HMOs) and Participating Provider Options (PPOs). An up-to- date list of participating plans is available. If the insurance company does not contract with the Northwell Health Laboratories, the patient is responsible to forward all balances due in full to the Northwell Health Laboratories. If all billing information is not provided at the time of service, your office may receive a letter requesting the missing information. Please indicate primary insurance when patient has more than 1 Insurance plan.

Patient Billing

If your patient elects to be billed by the Northwell Health Laboratories, the patient becomes responsible for full payment. The laboratory offers a financial assistance program for those who qualify. Patients may call 800-995-5727 Monday through Friday from 9:00 a.m. to 5:00 p.m. for more details. In order for the patient to be billed directly, the following information must be included on the requisition:

- Patient name (last, first, middle)
- Patient current address (including city, state, and zip code)
- Patient Social Security number
- Patient current phone number (including area code)
- Requesting physician name and address

If the patient has insurance coverage please refer to "Insurance—Third Party Billing" for information.

Client Billing

An institutional or physician research study client will receive an itemized statement sent out approximately the second week of each month detailing the previous month's services. The client will only be charged for the specific tests requested and performed. If the client requests test be billed to a patients insurance the proper information must be provided as outlined above. Any discrepancies must be reported in writing. Adjustments will appear on subsequent invoices. Studies that are approved by the Principal Investigator must include a fund/grant number in order to be given to the representative setting up any new study.

Medicare

Under the Medicare statute, a laboratory must bill Medicare directly for clinical laboratory services. Physicians may not bill the Medicare program for laboratory tests they do not perform. Clinical diagnostic tests are reimbursed on the basis of a fee schedule. The ordering physician's UPIN is required on all requisitions for Medicare billing and effective May, 2007 the Requesting physician National Provider Identifier (NPI) number must be included. The following information is required:

- Patient name (last, first, middle) (as the name appears on the Medicare card)
- Patient date of birth
- Patient gender
- Patient current address (including city, state, and zip code)
- Patient current phone number (including area code)
- Medicare number (9 digits plus 1 alpha suffix)
- Referring physician name
- Referring physician UPIN (alpha prefix followed by 5 digits)
- Requesting physician National Provider Identifier (NPI) number
- ICD-10 diagnosis code to the highest level of specificity or narrative diagnostic information documented from the patient's chart notes for that date of service.
- Physicians supplying a routine physical diagnosis for Medicare patients of V70.0 will result in Medicare denying claims. The service will be the patient's responsibility. If there is a diagnostic reason for the visit or test being ordered, that diagnosis should be provided.

Medicaid

Like Medicare, the Medicaid statute does not permit physicians to bill for laboratory tests they do not perform. A laboratory must bill Medicaid directly for clinical laboratory services. Testing ordered for New York Medicaid beneficiaries and referred to an "outside" reference laboratory will be billed directly by the reference laboratory. If a patient is enrolled with an additional insurer, such as Medicare or a private carrier, Medicaid can only be billed after those parties have been billed. Currently, New York Medicaid does not permit test order panels. Therefore, each test must be submitted individually. Since Medicaid sets frequency limits for testing, it will be necessary for the physician to complete a Threshold Authorization form should a patient exceed the established limit. This form is not obtainable through the laboratory. The physician will be notified if the laboratory billing department receives a denial due to exceeding threshold limits. (**Medicaid requires that all orders must have the signature of the ordering Physician on each requisition.)**