

**REQUEST FOR ENVIRONMENTAL BLOOD LEAD (Pb)**

**PRINT LEGIBLY** WIC Client?  Yes  No Gender:  F  M

Patient SS#: \_\_\_\_\_

**Specimen Type:** (Select one)  
 Capillary Tube  Venous  
 Capillary Filter Paper

**Purpose:** (Select one)  
 Screen  Follow Up  
 Venous Confirm

**Protocol:** (Select one)  
 Traditional  
 Waterless

Sample Collector: \_\_\_\_\_

Select Bill To:  Medicaid  MCO / Insurance (Below)  Clinic  Other

Referral # (if applicable): \_\_\_\_\_

MCO / Insurance Name (provide front & back copy of insurance card is BEST)  
 Insurance Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Insured Last Name (if different than patient) \_\_\_\_\_ Insured First Name (if different) \_\_\_\_\_  
 Insurance Address (claim mailing address)  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ICD-97 DIAGNOSIS CODE  
 PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

Street ADDRESS, CITY, ST, and ZIP required by State CLPPP and for 3<sup>rd</sup>-party billing

Done forget RACE & ETHNICITY; required by State CLPPP

SSN generally required by State CLPPP

If known, please provide diagnosis code

Designate TYPE of specimen; PURPOSE of blood draw; and PROTOCOL used: Traditional (white kit env) or Waterless (green kit env)

If payer is "straight" Medicaid, designate here, and provide NUMBER

Test ID Barcode prints here

3959 E. Arapahoe Rd.  
 Suite 100  
 Centennial, CO 80122  
 800-842-7069

**TAMARAC MEDICAL**  
 SUBMITTING HEALTH PROF

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 County: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**Patient** Date of Birth: \_\_\_\_\_ Blood Draw Date: \_\_\_\_\_  
 Guardian Name: \_\_\_\_\_ Guardian Phone#: ( ) \_\_\_\_\_

Apply Labels in Dotted Area

Customer Account # (Include on Every Form): \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

(Results and Fees for Unpaid Charges Be Sent To Submitter)  
 Mail  Send Report By \_\_\_\_\_  
 Signature of Physician/Nurse \_\_\_\_\_

INSURANCE / STATE MCO  
 MEDICAID  
 TAMARAC MEDICAL USE ONLY

REFERENCE RANGE IS PRINTED ON RESULT COPY

LEAD (Pb)

REPORTED

Code

White Copy: Send To Lab (Apply Label)  
 Yellow Copy: For Your Records (No Label)

Lab Director:  
 Dr. Richard J. Rosenbaum  
 01/12

Please PRINT clearly; cursive is tough to read

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Date of BIRTH & Blood DRAW Date Required

Stick customer ID label with barcode here; you may write info as well; call us for labels

Physician or Nurse sign here

Guardian NAME & PHONE required by State CLPPP

If payer is MCO/Insurance, designate with check above; provide all billing info: INSURANCE CO NAME, POLICY #, GROUP #, MEMBER NAME, COMPLETE CLAIM MAILING ADDRESS (including City, ST, and Zip)

If no 3<sup>rd</sup> party payer, designate CLINIC payer (generally); no other billing info required