

|                                                                                                                                     |  |                                                                                  |                                             |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
|                                                                                                                                     |  | Centers Laboratory Inc.                                                          |                                             | Client Information                                                                                                      |  |
|                                                                                                                                     |  |  |                                             | <b>ACCOUNT:</b><br>Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br>3400 Cannon Place<br>Bronx, NY 10463 |  |
|                                                                                                                                     |  |                                                                                  |                                             |                                                                                                                         |  |
| Patient Information                                                                                                                 |  |                                                                                  | Ordering Physician Information              |                                                                                                                         |  |
| <b>NAME:</b> Keohane, John                                                                                                          |  |                                                                                  | <b>PHYSICIAN NAME:</b> Samaniego, Robert MD |                                                                                                                         |  |
| <b>D.O.B.:</b> 1/20/1946 <b>SEX:</b> Male                                                                                           |  |                                                                                  | <b>UPIN:</b>                                |                                                                                                                         |  |
| <b>I.D.:</b> 343 <b>S.S.N:</b> 106-36-3839                                                                                          |  |                                                                                  | <b>NPI:</b> 1083632392                      |                                                                                                                         |  |
| <b>UNIT:</b> East 3 <b>ROOM/BED:</b> 316/A                                                                                          |  |                                                                                  | <b>DIAGNOSIS CODES</b>                      |                                                                                                                         |  |
| <b>ORDER DATE/TIME:</b>                                                                                                             |  |                                                                                  | F20.0                                       |                                                                                                                         |  |
| <b>COLLECTION DATE/TIME:</b>                                                                                                        |  |                                                                                  |                                             |                                                                                                                         |  |
|                                                                                                                                     |  |                                                                                  | <b>FASTING:</b> Y / N                       |                                                                                                                         |  |
| Responsible Party                                                                                                                   |  |                                                                                  | TEST LIST                                   |                                                                                                                         |  |
| <b>NAME:</b> Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br><b>ADDRESS:</b> 3400 Cannon Place<br>Bronx, NY 10463   |  |                                                                                  | CBC Q 2Wks                                  |                                                                                                                         |  |
| Primary Billing (INSURANCE)                                                                                                         |  |                                                                                  |                                             |                                                                                                                         |  |
| <b>INS NAME:</b> Medicaid<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> YB01116F          |  |                                                                                  |                                             |                                                                                                                         |  |
| 2nd Billing (INSURANCE)                                                                                                             |  |                                                                                  |                                             |                                                                                                                         |  |
| <b>INS NAME:</b> Medicare Part A<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> 106363859M |  |                                                                                  |                                             |                                                                                                                         |  |
|                                                                                                                                     |  | INTERNAL CONTROL                                                                 |                                             |                                                                                                                         |  |
| ____ L-Lav ____ Cultrt ____ R-Red ____ S-SST ____ GY-Grey ____ Lt. Blue ____ Black & Yellow Tube                                    |  |                                                                                  |                                             |                                                                                                                         |  |
| ____ G-Green ____ Y-Yellow ____ W-PPT ____ RB-Royal Blue ____ Strl Cup                                                              |  |                                                                                  |                                             |                                                                                                                         |  |
| ____ Viral Cul ____ O&P ____ BLD Cul ____ FS-Froz ____ Slide ____ Thinprep Vial                                                     |  |                                                                                  |                                             |                                                                                                                         |  |
| ____ Rand Urine Cup ____ 24 hr ____ U-Urn Tube ____ Timed ____ BORICULT                                                             |  |                                                                                  |                                             |                                                                                                                         |  |
| LAB I.D. #                                                                                                                          |  |                                                                                  |                                             |                                                                                                                         |  |

|                                                                                                                                     |  |                                                                                  |                                             |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
|                                                                                                                                     |  | Centers Laboratory Inc.                                                          |                                             | Client Information                                                                                                      |  |
|                                                                                                                                     |  |  |                                             | <b>ACCOUNT:</b><br>Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br>3400 Cannon Place<br>Bronx, NY 10463 |  |
| Patient Information                                                                                                                 |  |                                                                                  | Ordering Physician Information              |                                                                                                                         |  |
| <b>NAME:</b> Keohane, John                                                                                                          |  |                                                                                  | <b>PHYSICIAN NAME:</b> Samaniego, Robert MD |                                                                                                                         |  |
| <b>D.O.B.:</b> 1/20/1946 <b>SEX:</b> Male                                                                                           |  |                                                                                  | <b>UPIN:</b>                                |                                                                                                                         |  |
| <b>I.D.:</b> 343 <b>S.S.N:</b> 106-36-3839                                                                                          |  |                                                                                  | <b>NPI:</b> 1083632392                      |                                                                                                                         |  |
| <b>UNIT:</b> East 3 <b>ROOM/BED:</b> 316/A                                                                                          |  |                                                                                  | <b>DIAGNOSIS CODES</b>                      |                                                                                                                         |  |
| <b>ORDER DATE/TIME:</b>                                                                                                             |  |                                                                                  | F20.0                                       |                                                                                                                         |  |
| <b>COLLECTION DATE/TIME:</b>                                                                                                        |  |                                                                                  |                                             |                                                                                                                         |  |
|                                                                                                                                     |  |                                                                                  | <b>FASTING:</b> Y / N                       |                                                                                                                         |  |
| Responsible Party                                                                                                                   |  |                                                                                  | TEST LIST                                   |                                                                                                                         |  |
| <b>NAME:</b> Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br><b>ADDRESS:</b> 3400 Cannon Place<br>Bronx, NY 10463   |  |                                                                                  | CBC Q 2Wks                                  |                                                                                                                         |  |
| Primary Billing (INSURANCE)                                                                                                         |  |                                                                                  |                                             |                                                                                                                         |  |
| <b>INS NAME:</b> Medicaid<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> YB01116F          |  |                                                                                  |                                             |                                                                                                                         |  |
| 2nd Billing (INSURANCE)                                                                                                             |  |                                                                                  |                                             |                                                                                                                         |  |
| <b>INS NAME:</b> Medicare Part A<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> 106363859M |  |                                                                                  |                                             |                                                                                                                         |  |
|                                                                                                                                     |  | INTERNAL CONTROL                                                                 |                                             |                                                                                                                         |  |
| ____ L-Lav ____ Cultrt ____ R-Red ____ S-SST ____ GY-Grey ____ Lt. Blue ____ Black & Yellow Tube                                    |  |                                                                                  |                                             |                                                                                                                         |  |
| ____ G-Green ____ Y-Yellow ____ W-PPT ____ RB-Royal Blue ____ Strl Cup                                                              |  |                                                                                  |                                             |                                                                                                                         |  |
| ____ Viral Cul ____ O&P ____ BLD Cul ____ FS-Froz ____ Slide ____ Thinprep Vial                                                     |  |                                                                                  |                                             |                                                                                                                         |  |
| ____ Rand Urine Cup ____ 24 hr ____ U-Urn Tube ____ Timed ____ BORICULT                                                             |  |                                                                                  |                                             |                                                                                                                         |  |
| LAB I.D. #                                                                                                                          |  |                                                                                  |                                             |                                                                                                                         |  |