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|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
|                                                                                                                                      |  | 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> Miller, Joyce                                                                                                           |  |                                                                                  | <b>PHYSICIAN NAME:</b> Talpada, Motibhai MD        |                                                                                                                         |  |
| <b>D.O.B.:</b> 5/24/1942 <b>SEX:</b> Female                                                                                          |  |                                                                                  | <b>UPIN:</b>                                       |                                                                                                                         |  |
| <b>I.D.:</b> 6469 <b>S.S.N:</b> 229-56-9949                                                                                          |  |                                                                                  | <b>NPI:</b> 1134502958                             |                                                                                                                         |  |
| <b>UNIT:</b> West 3 <b>ROOM/BED:</b> 331/B                                                                                           |  |                                                                                  | <b>DIAGNOSIS CODES</b>                             |                                                                                                                         |  |
| <b>ORDER DATE/TIME:</b>                                                                                                              |  |                                                                                  | D72.829                                            |                                                                                                                         |  |
| <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    |  |                                                                                  | UA, C&S may straight catheter to obtained specimen |                                                                                                                         |  |
| 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> RP17420H           |  |                                                                                  |                                                    |                                                                                                                         |  |
| 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> 3P17U47GT34 |  |                                                                                  |                                                    |                                                                                                                         |  |
|                                                                                                                                      |  | 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. #                                                                                                                           |  |                                                                                  |                                                    |                                                                                                                         |  |

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| <b>D.O.B.:</b> 5/24/1942 <b>SEX:</b> Female                                                                                          |  |                                                                                  | <b>UPIN:</b>                                      |                                                                                                                         |  |
| <b>I.D.:</b> 6469 <b>S.S.N:</b> 229-56-9949                                                                                          |  |                                                                                  | <b>NPI:</b> 1134502958                            |                                                                                                                         |  |
| <b>UNIT:</b> West 3 <b>ROOM/BED:</b> 331/B                                                                                           |  |                                                                                  | <b>DIAGNOSIS CODES</b>                            |                                                                                                                         |  |
| <b>ORDER DATE/TIME:</b>                                                                                                              |  |                                                                                  | D72.829                                           |                                                                                                                         |  |
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| Primary Billing (INSURANCE)                                                                                                          |  |                                                                                  |                                                   |                                                                                                                         |  |
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| 2nd Billing (INSURANCE)                                                                                                              |  |                                                                                  |                                                   |                                                                                                                         |  |
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