Litholink
LabCorp Specialty Testing Group

# Collection Data Form

www.litholink.com
800 338 4333
*(M–F, 7:30am–6:00pm CT)*

## Patient Information *Complete form and return it with your sample(s).*

LAST NAME: FIRST NAME: MI:

ADDRESS:

CITY: STATE: ZIP CODE:

DATE OF BIRTH: PATIENTS LAST 4 DIGITS OF SS NUMBER:

GENDER: (CIRCLE ONE) MALE FEMALE PARENT/GUARDIAN NAME:

PRIMARY PHONE NUMBER: ( ) EMAIL:

## Prescribing Physician

☐ I have included my Test Request Form that was given to me by my physician.*(no further Physician Information necessary)*

PHYSICIAN LAST NAME: FIRST NAME: OFFICE PHONE:

## Collection 1 (required)

START TIME: am

STOP TIME: am

DATE COLLECTION ENDED: / /

TOTAL VOLUME:* ml

**Total Volume equals amount of urine in orange jug.*

## Collection 2 (if performed)

*Collection 2 start time MUST MATCH Collection 1 Stop time.*

START TIME: am

STOP TIME: am

DATE COLLECTION ENDED: / /

TOTAL VOLUME:* ml

## Medical History - *(Used for reporting purposes.)*

WEIGHT: LBS OR KG HEIGHT: FT IN OR CM

| Name of Medications/supplements you are taking for the treatment of Kidney Stones: | Date started | Date ended |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Medical Information (Check ALL that apply to you and provide dates for events checked)

Have you ever been diagnosed with either of these two conditions below?

☐ Crohn's / /

☐ Ulcertative colitis / /
Date Diagnosed

Have you been placed on either diet for the treatment of Kidney stones?

☐ Low Sodium Diet / /

☐ Low Fat Diet / /
Date Started

Have you ever had any of the surgeries listed below? Check all that apply

☐ Colectomy / /

☐ Ileostomy / /

☐ Gastric bypass/ Weight loss surgery / /

☐ Small Bowel Resection / /
Date of Event

# Insurance Information Form

**All information must be filled out completely on both sides of the form and returned with your sample(s).**

## Patient Information (Please send a photocopy of your insurance card.)

LAST NAME: FIRST NAME: DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

## Primary Insurance Information

INSURANCE PLAN NAME: PHONE NUMBER: ( )

POLICY, SUBSCRIBER OR MEMBERSHIP NUMBER:

GROUP NUMBER OR PLAN CODE NUMBER:

INSURANCE COMPANY ADDRESS FOR CLAIM SUBMISSION:

CITY: STATE: ZIP CODE:

## Complete this section only if you are covered by insurance under someone else's policy.

INSURED LAST NAME: FIRST NAME: MI:

INSURED DATE OF BIRTH: LAST 4 DIGITS OF SS NUMBER:

YOUR RELATIONSHIP TO THE PRIMARY INSURED: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

## Secondary Insurance Information (Complete this section only if you have additional insurance.)

INSURED LAST NAME: FIRST NAME: MI:

INSURED DATE OF BIRTH: LAST 4 DIGITS OF SS NUMBER:

YOUR RELATIONSHIP TO THE SECONDARY INSURED: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

INSURANCE PLAN NAME: PHONE NUMBER: ( )

POLICY, SUBSCRIBER OR MEMBERSHIP NUMBER:

GROUP NUMBER OR PLAN CODE NUMBER:

INSURANCE COMPANY ADDRESS FOR CLAIM SUBMISSION:

CITY: STATE: ZIP CODE:

### Insurance Billing and Privacy Information

I authorize Litholink to bill my insurance company for the laboratory services ordered by my physician. I have completed the insurance information form for that purpose. Litholink will bill you for your coinsurance and/or deductible. If payment is a hardship please advise. Call us with any questions about billing or insurance at 800 338 4333. We have provided you with a notice of "Litholink's Privacy Practices" in the kit materials regarding the use by us of your personal health information. This notice includes your right to request and obtain your personal health information and to restrict the use of such information. I acknowledge receipt of the notice of "Litholink's Privacy Practices."

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE:

PRINT NAME: DATE: