Insurance Reimbursement / Itemized Receipt

Name: _____ **Physician's Name:**_____

Address: _____ **Address:**_____

_____ _____

_____ _____

Date of Service: _____ **Diagnosis Code(s)/ICD-9:**_____

(Date of service is located on the test report) _____

_____

Complete Thyroid Profile

BLOOD SPOT: TSH, fT3, fT4, TPO

Place an "X" in the box next to each test that was performed.

X	Test	CPT Code	Quantity	Price
X	Thyroid Stimulating Hormone (Blood) TSH	84443	1	$65.00
X	Free Triiodothyronine (Blood) fT3	84481	1	$60.00
X	Free Thyroxine (Blood) fT4	84339	1	$60.00
X	Thyroid Peroxidase Antibody (Blood) TPO	86376	1	$65.00
Total Amount paid				$250.00

Test(s) Performed by: ZRT Laboratory
8605 SW Creekside Pl
Beaverton, OR 97008

CLIA# 38D 0960950
EIN/Tax ID # 93-1252924
Place of Service: 81
NPI# 1740356872

Complete your insurance Company's claim form. Attach a copy of the receipt for the kit purchase along with the doctor's order or prescription with Diagnosis Code(s). Mail all of the information listed in addition to this form to your Insurance Company.

Save a copy of these forms for your records.