

CUSTOM CLIENT REQUISITION

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<p>PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name First MI</p> <hr/> <p>Address Birth Date Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City SS #</p> <hr/> <p>State Zip Home Phone</p> <hr/> <p>Hospital/Physician Office Patient ID # Accession #</p> <hr/> <p><small>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</small></p> <p>INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p>PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p>ABN: <input type="checkbox"/> Yes <input type="checkbox"/> No WORKERS COMP: <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p>PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name First MI</p> <hr/> <p>Beneficiary / Member # Group #</p> <hr/> <p>Claims Address City State Zip</p> <hr/> <p>SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach)</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p>	<p style="text-align: center;">CLIENT INFORMATION</p> <hr/> <p>ORDERING PHYSICIAN CONTACT</p> <hr/> <p>Physician Name</p> <hr/> <p>Physician NPI#</p> <hr/> <p>Physician Phone</p> <hr/> <p>Physician Email</p> <hr/> <p><input type="checkbox"/> Call results to phone number: (_____) _____</p> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <hr/> <p>SPECIMEN INFORMATION</p> <p>Collection Date: ____/____/____ Time: _____</p> <p>Specimen Type <input type="checkbox"/> Serum <input type="checkbox"/> Plasma</p> <p><input type="checkbox"/> Urine – volume _____ # hours _____</p> <p><input type="checkbox"/> Whole Blood <input type="checkbox"/> Other (specify) _____</p> <p><input type="checkbox"/> Fasting _____ hours <input type="checkbox"/> Non-fasting</p>
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