PRIORITY

☐ Stat
☐ Fax Results To:_____
☐ Call Results To: _____
☐ Copy To: _____

Client Info Printed Here

SSN #_____ 011742

Patient's Legal Name _____
(Last) (First) (MI)

Collection Date/Time _____

First Initial + Last Name of Collector _____

Legal Name:				
	011742	011742	011742	011742
Legal Name:				
	011742	011742	011742	011742

Ordering Physician: _____
(MANDATORY) (First) (Last)

Sex: _____ DOB: _____

Patient Phone #:_____

INSURANCE INFORMATION MUST BE COMPLETED OR WILL BE PROCESSED AS SELF-PAY OR PHYSICIAN-BILL

Subscriber Name: Last First MI

Patient's Address: Apt #

City State Zip

Primary Insurance: Policy #: Group #:

Secondary Insurance: Policy #: Group #:

Please provide a diagnosis code for all tests ordered as supported by your patient's records.

For any patient of any payor (including Medicare and Medicaid) that has a medical necessity requirement, you should only order those tests which are medically necessary for the diagnosis and treatment of the patient. Those tests with * may require a signed ABN.

Other Tests: _____

Comments: _____

LAB USE ONLY:

ACC # _____

ACCT # _____

ENTERED BY: SQ _____ SMS _____

KEY	Gold	Lt. Blue	Dk. Blue	Green	Gray	Lavender	Plain Red	Random Urine	Urine Culture	24hr Urine
# of tubes:										Volume