Cleveland Clinic
Laboratories

☐ STAT

CUSTOM CLIENT REQUISITION

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name	First MI
Address	Birth Date Sex ☐ M ☐ F
City	SS #
State Zip	Home Phone
Hospital/Physician Office Patient ID #	Accession #

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)

BILL TO: ☐ Client ☐ Patient ☐ Insurance **(Complete insurance information below)**

ABN ☐ Yes ☐ No **WORKERS COMP:** ☐ Yes ☐ No DOI: _____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name	First MI
Beneficiary / Member #	Group #
Claims Address	City State Zip

SECONDARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name	First MI
Beneficiary / Member #	Group #
Claims Address	City State Zip

DIAGNOSIS CODE (REQUIRED)

1. _____ 2. _____
3. _____ 4. _____

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

CLIENT INFORMATION

PHYSICIAN SIGNATURE REQUIRED

Physician Signature Date / Time

Physician Print Name NPI#

Date collected: ___/___/___ Time: _____

Collected by: _____

Specimen Type: ☐ Serum ☐ Plasma

☐ Urine - volume _____ #hours _____

☐ Whole Blood ☐ Other (specify) _____

☐ Fasting _____hours ☐ Non-fasting

☐ Send additional report

Physician: _____

Address: _____

City, State, Zip: _____

WHITE: Laboratory Copy YELLOW: Billing Copy PINK: Client Copy