Cleveland Clinic Laboratories

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

CUSTOM CLIENT REQUISITION

<<FORM_ID>>

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 #

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.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

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: ☐ No ☐ Yes (if Yes, please attach)

DIAGNOSIS CODE (REQUIRED) ICD-9 Codes: 1. _____ 2. _____ 3. _____

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time: _____

Specimen Type ☐ Serum ☐ Plasma

☐ Urine – volume _____ # hours _____

☐ Whole Blood ☐ Other (specify) _____

☐ Fasting _____ hours ☐ Non-fasting

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