REQUISITION FORM

tests accordingly.

Provider Name Printed:		Date:		Provider Signature:	

CLIENT TEST MENU

[588C: DAT,5150: IBA]

Outsourced Tests:

[5094: CS, 5600: een, 5600: Cardio Profile, 5150: FH,:anotherprofileCardio Profile, 5150: Female Hormones, 5140: Male Hormones, 5093: Comprehensive thyroid proooofiel,5111:anotherprofile]

Takehome Kits:

[5200: Comp Stool, 4001: NeuroTransmitter, 1600: AAT]

SPECIMEN INFORMATION	Collection Date:	09/04/18

PRACTICE INFORMATION	NPI#:			
Clinic Name:				
Provider Name:	buttface			
Street Address:		City, State, & Zip:		
Phone:		Fax:	Email:	

PATIENT INFORMATION	DOB:	08/08/78	Sex:	Male ☐ Female ☐
Last Name:	smith	First Name:	john	
Street Address:		City, State, & Zip:		
Phone:		Fax:	Email:	

BILLING AND INSURANCE INFORMATION

Please attach a copy of the front and back of the patient's primary and secondary insurance card to this requisition.

Name on Credit Card:																						
Card#																	Expiration Date:			-		

☐ Clinician Pay
☐ Patient Pay
☐ Insurance Simple Pay Plan

In the event Insurance declines:

☐ I authorize Precision Analysis Labs to charge the credit card provided the cash price for the test.
☐ I do not authorize my card provided to be charged, please cancel my test(s) ordered if insurance is not approved.

ASSIGNMENT OF BENEFITS AND CONSENT TO ACCESS TO LAB RESULTS

Patient Signature: Date:

REV 6.1.18