

REQUISITION FORM

PROVIDER INFORMATION

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Provider Name Printed:

Date:

Provider Signature:

CLIENT TEST MENU

Dunwoody Labs Tests:

Outsourced Tests:

Takehome Kits:

SPECIMEN INFORMATION

Collection Date:

PRACTICE INFORMATION

NPI#:

Clinic Name:

Provider Name:

Street Address:

City, State, & Zip:

Phone:

Fax:

Email:

PATIENT INFORMATION

DOB:

Sex:

Male

☐

Female

☐

Last Name:

First Name:

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:

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☐ 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

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claim.

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