REQUISITION FORM

tests accordingly.

Provider Name Printed:		Date:		Provider Signature:	

CLIENT TEST MENU

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:			-		

☐ 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