ACCU | REFERENCE MEDICAL LAB

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SPECIMEN COLLECTION
TIME ☐ AM ☐ PM DATE

General Test Requisition

ACCT:

☐ Call results to: (____) _______________
☐ Fax results to: (____) _______________

Patient Information

Last Name	First Name	MI
☐ Male ☐ Female	D.O.B. / /	
Address (Street)		Apt # Floor Room #
City State Zip		Telephone #
Responsible Party/Subscriber	Social Security #	Client Chart/Pt. ID#

Billing Information*	☐ Bill Patient	☐ Bill Client	☐ Bill Medicare	☐ Bill Medicaid	☐ Bill Insurance	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Medicare # (Include Prefix/Suffix)		Medicaid #				State

INSURANCE

Insurance Company Name			Telephone #
Subscriber Member #	Location	Group #	
Insurance Address	Physician's Provider		
City	State	Zip	

MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)

I have read the ABN on the reverse. If Medicare denies payment, I agree to pay for the identified test(s).

X

Patient's Signature Date

ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED

DIAGNOSIS/SIGNS SYMPTOM IN ICD-9 FORMAT (Highest Specificity)

24-HOUR URINE VOLUME IN ML

FASTING ☐ YES ☐ NO

STAT

LAB USE ONLY