COVID-19 TESTING REQUISITION

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PATIENT INFORMATION

First Name ______________________________

Last Name ______________________________

DOB ______/______/______ (Month / Day / Year) ❑ Male ❑ Female

Address ______________________________

City ________________ State ______ Zip __________

Email ________________ Phone __________

❑ White ❑ Asian
❑ Black ❑ Native American
❑ Hispanic ❑ Other ______________

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PROVIDER INFORMATION

Physician Name ______________________________

Facility Name ________________ NPI# __________

Address ________________ City __________

State ____ Zip __________ Phone ______________

Fax ______________ Email ______________________

SPECIMEN COLLECTION

❑ **NP** ❑ **OP** ❑ **Nasal**

Date of collection / /

Time of collection : ❑ AM ❑ PM

INSURANCE INFORMATION

Please select one and complete the required information:

☐ **Insured**

Insurance Carrier ______________________________

Insurance ID # ______________________________

Insurance Group # ______________________________

☐ **Uninsured**

Social Security # ______________________________

State ID # ______________________________

Issuing State ______________________________

☐ **Self Pay**

DIAGNOSIS CODE(S) FOR COVID-19

________ ________ ________ ________

________ ________ ________ ________

INSURANCE RELEASE/CONSENT

Consent/Insurance Release: ❑ Self Pay

I voluntarily consent to the collection and testing of my specimen. I authorize the laboratory to release the result of this testing to the ordering facility, insurance company/federal/state/local authorities. Furthermore, I authorize my insurance benefits directly to Woodhills Labs for the services I receive. I will be responsible for any payments denied by the Insurance/Government or in case of self pay.

Signature: ______________________ Date: __________

ORDERING PHYSICIAN'S SIGNATURE

Signature: ______________________ Date: __________

EMAIL IN BLOCK LETTERS:

____

You will receive an email as soon as your results are ready. Please follow the instructions to access your results.

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