1901 EAST LINDEN AVE.
SUITE 4, LINDEN, NJ 07036
T: (908) 474-1004
F: (908) 474-0032

ACCU | REFERENCE MEDICAL LAB℠

GENERAL TEST REQUISITION

ACCT:

☐ Call results to: (___) _____

☐ Fax results to: (___) _____

SPECIMEN COLLECTION

Date: ___/___/___ Time: ___:___ ☐ am ☐ pm

PATIENT INFORMATION

Last Name: _____ First Name _____

Middle Name: _____ ☐F ☐M DOB ___/___/___ Phone: (___) _____

Address: _____ Apt # Floor Room # _____

City: _____ State: _____ Zip: _____ Client Chart/Pt. ID _____

Responsible Party/Subscriber _____ Social Security # _____

BILLING INFORMATION

☐ Patient ☐ Client ☐ Medicare ☐ Medicaid ☐ Insurance

RELATIONSHIP

☐ 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: _____

ABN NOTICE

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

Patient 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