# SPECIAL SEND-OUT
# LABORATORY TEST REQUEST FORM

- This form **MUST** be completed and submitted to Specimen Receiving when the FAHC laboratory is asked to ship any type of specimen to a laboratory that we do not routinely send to (Labs we routinely send-to include: Mayo Medical Laboratory and VT State Lab). **Mon.-Thurs.Only**
- Fax form to 847-2358 and call 847-4763 for confirmation from Specimen receiving Supervisor.
- This form **MUST** accompany a completed laboratory requisition from the performing lab (not an FAHC laboratory requisition).

## PATIENT INFORMATION

**Date to be drawn:**___________________________ **Where patient will be drawn:**______________________________________

**Patient Full Name:**_______________________________________________**DOB:**______________ **MRN:**________________________

**Diagnosis Code(s)**:_________________________________________________________________________________________

☐ **Bill Provider:** Please provide account number (9____--___________ ) or call 847-5121 to speak to a Marketing Rep.

☐ **Bill Patient or Patient Insurance** (Please include insurance information):

☐ **Performing lab listed to bill patient** (Include copy of patients insurance card, back and front).

**Responsible Party Name:** _______________________________________________**Phone Number:** _____________________

**Address (Street, Town, State, Zip Code):**

____________________________________________________________________________________________________

**Medicare No.**______________**Medicaid No.** ______________**Managed Care Medicaid No:**_________________**State**:_________

**Insurance Name:** _____________________________**Cert. No.** ________________________**Group** _________________________

**Subscriber Name:**_______________________________________________**DOB**_____________**Relationship**________________

**Employer**____________________________________________________________________________________________

## YOUR PRACTICE INFORMATION

**Person Filling Out Form:**__________________________________________**Telephone Number:**____________________________

**Practice Name:**_____________________________________________________________________________________________

**Address:**_________________________________________________________________________________________________

**Ordering Provider:** _______________________________________________**Additional Copy To:**_________________________________

**Physician Signature**:_______________________________________________________________________________________

## PERFORMING LABORATORY & TESTING INFORMATION

➡ **You must send Specimen Receiving a completed laboratory requisition from the performing laboratory**

**Specimen Type:** ____________________**Volume Required**:_________________**Shipping Temperature**:_____________________

**Test Name:** _____________________________________________________**Test CPT:** _____________**Test Price:** ___________

**Performing Lab:**_________________________________________________________ **CLIA License No:**____________________

**Lab Address (Street, Town, State, Zip**

____________________________________________________________________________________________________

**Lab Phone:**_____________________________**CLIA REQUIRES THAT A COPY OF RESULTS BE SENT TO FAHC LABORATORY**

In the event that your insurance does not cover these services you will be responsible for the charges. (form updated 9/10/10)

Print name:_____________________________________Signature:_____________________________________________________Date:________________________