ACUPATH LABORATORIES, INC
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28 S. Terminal Dr., Plainview, NY 11803

"FOR THE ABSOLUTE HIGHEST STANDARD IN MOLECULAR PCR" © 2023

MOLECULAR PCR REQUISITION FORM

MOLPCR-01

ANY OMISSION MAY RESULT IN DELAY OF REPORT

PHYSICIAN INFORMATION:

Ordering Physician's Signature:_____
(REQUIRED)

COLLECTION DATE:_____/_____/20_____

☐ **STAT**

☑	MOLECULAR PCR TESTS / PANELS
	COVID19 (Nasal)
	COVID19 (Saliva)
	COVID19 (Nasal), Flu A, Flu B
	Flu A, Flu B
	GI Pathogen (BioFire®)
	Nail Fungal
	RSV, Flu A, Flu B
	~~STI~~ *
	UTI
	~~Women's Health~~ *
	Wound Panel

** coming soon*

ICD-10 CODE(S) ARE REQUIRED.

Disclaimer: In order to prevent a delay in the processing and reporting of your specimen(s), ICD-10 CODE(S) ARE REQUIRED.

FOR LAB USE ONLY:

PATIENT INFORMATION

SS# _____ DATE OF BIRTH _____ M☐ F☐

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

( ) TEL # _____ CHART # _____ PATH# _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD, OR FILL OUT INSURANCE SECTION BELOW.

PATIENT'S PRIMARY INSURANCE

☐ BILL TO MEDICARE ☐ BILL TO MEDICAID ☐ BILL TO INSURANCE ☐ BILL TO PATIENT

INSURED'S NAME_____ D.O.B._____/_____/_____

PT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURANCE CO:_____

POLICY #_____SS#_____-_____-_____

GROUP NAME:_____REFERRAL#_____

*INSURANCE ADDRESS:_____

CITY_____STATE_____ZIP_____

SECONDARY INSURANCE

INSURED'S NAME_____ D.O.B._____/_____/_____

PT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURANCE CO:_____

POLICY #_____SS#_____-_____-_____

GROUP NAME_____REFERRAL#_____

*INSURANCE ADDRESS_____

CITY_____STATE_____ZIP_____

I authorize the release to my insurance carrier any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc.
I hereby give my consent to PCR based testing. I also acknowledge that my physician has explained the reason for the test and about possible medical decisions that will be made based on the findings from the test.
I understand that the lab test may be sent to a non-participating laboratory for quicker turn around and quality of the service and I am made aware of possible higher out of pocket expenses.
I hereby authorize the lab and its personnel to appeal on my behalf with the insurance for any denial of payment.
I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature:_____
(REQUIRED)
Authorized Signature:_____

** De-identified patient data may be used for R&D purposes.*

Remove labels and affix to container or tube
(1 label per container)

NOT FOR PATIENT USE