ACCU REFERENCE MEDICAL LAB®

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COVID-19 NASAL / NASOPHARYNX REQUISITION FORM

PHYSICIAN'S INFORMATION

ACCOUNT #38072
TOWN OF FAIRHAVEN
146 WASHINGTON STREET
FAIRHAVEN, MA 02719
PH: 508.994.1428
FAX: 508.994.1515

ORDERING PROVIDER: M. BIVENS

PATIENT'S INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE	
DATE OF BIRTH (M/D/Y)	GENDER ☐ M ☐ F	RACE Not Required	ETHNICITY Not Required
ADDRESS			APT #
CITY	STATE MA	ZIP	PHONE NUMBER / EMAIL

BILLING INFORMATION

- ☐ ~~BILL INSURANCE~~
- ☐ ~~BILL PATIENT~~
- ☐ ~~BILL MEDICAL PRACTICE~~

SPECIMEN COLLECTION

DATE	
TIME	☐ AM ☐ PM

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME	Not Required	Not Required
ADDRESS		
CITY / STATE / ZIP		
PATIENT ID		
GROUP No #		
PATIENT RELATIONSHIP TO INSURED	☐ SELF ☐ SPOUSE ☐ DEPENDANT	☐ SELF ☐ SPOUSE ☐ DEPENDANT

RESPIRATORY PANEL

■ C455 2019 NOVEL CORONAVIRUS DISEASE (COVID-19)
SOURCE: NASAL / NASOPHARYNX

DIAGNOSES (ICD-10 CODES)

PHYSICIAN'S SIGNATURE _____ DATE _____