

General Test Requisition  
 1622 South Wood Avenue, Linden, New Jersey 07036  
 (908)862-4404 Fax (908)862-6655

ACCT: Patient Information or Client I.D. Label  
 Last Name: MI First Name: MI  
 Male Female D.O.B. / /  
 Address (Street) Apt # Floor Room  
 City State Zip Telephone #  
 Responsible Party-Subscriber Social Security # Client Chart Pt. ID#

Billing information Bill Patient Bill Client Bill Medicare Bill Medicaid Bill Insurance SELF INSURE CHILD OTHER  
 Medicare # (include Prefix Suffix) Medicaid #

Insurance Company Name Telephone #  
 Subscriber Member # Location Group # I have read the A/BN on the reverse.  I have not read the A/BN on the reverse.  Do not bill my insurance.  Other (specify)  
 Insurance Address Physician's Provider  
 City State Zip X Patient's Signature Date

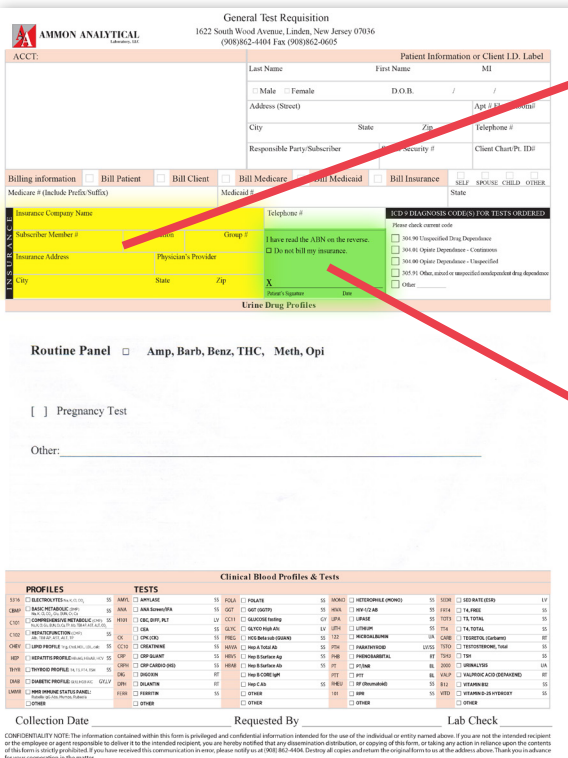
Urine Drug Profiles  
 Routine Panel  Amp, Barb, Benz, THC, Meth, Opi  
 Pregnancy Test  
 Other: \_\_\_\_\_

Clinical Blood Profiles & Tests  
 PROFILES TESTS  
 Collection Date Requested By Lab Check

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## STEP 1: FILL OUT THE PATIENTS NAME

PLEASE PRINT THE PATIENTS NAME CLEARLY OR USE THE LABELS PROVIDED BY CLIENT SERVICES.



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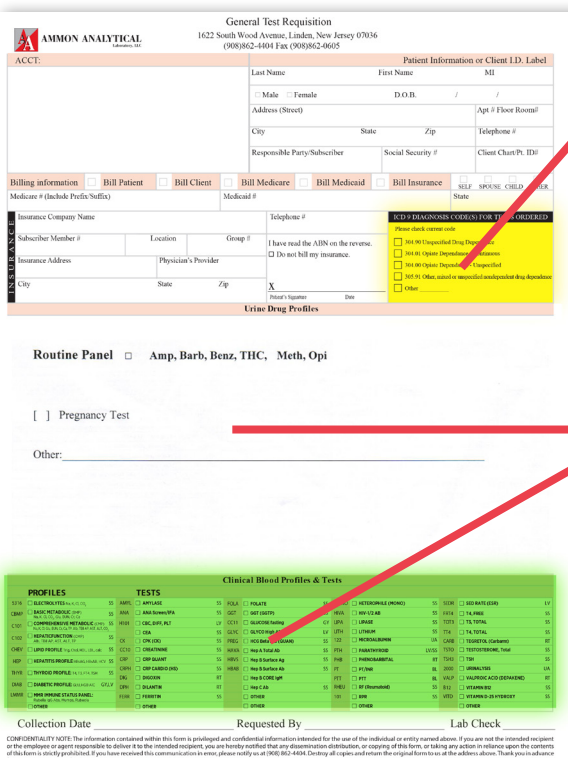
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## STEP 2: BILLING INFORMATION

MAKE A CHECK MARK IN THE BOX NEXT TO THE CORRECT PARTY WHO WILL BE RESPONSIBLE FOR PAYMENT.



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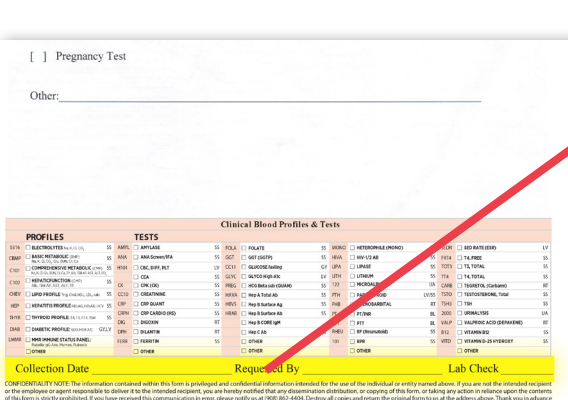
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## STEP 3: INSURANCE INFORMATION

IF THE INSURANCE INFORMATION HAS BEEN CHANGED PLEASE FILL IN THE CORRECT INFORMATION HERE.



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## STEP 4: ADVANCED BENEFICIARY NOTICE (ABN)

THE PATIENT MUST READ THE ABN ON THE BACK SIDE OF THE FORM THEN SIGN NEXT TO THE X.

## STEP 5: ICD 9 DIAGNOSIS CODE(S)

CHOOSE THE CORRECT CODE(S) FOR REQUESTED PROCEDURES. ADDITIONAL ICD9 CODES CAN BE FOUND ON THE OPPOSITE SIDE OF THE FORM.

## STEP 6: IDENTIFY THE PROCEDURE

IDENTIFY THE TEST(S) THAT ARE BEING REQUESTED.

## STEP 7: COLLECTION DATE AND CLIENT SIGNATURE

PROVIDE COLLECTION DATE OF THIS SPECIMEN AND SIGN AS AUTHORIZED REPRESENTATIVE.