ACCU | REFERENCE MEDICAL LAB®

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COVID-19 NASAL / NASOPHARYNX REQUISITION FORM

PHYSICIAN'S INFORMATION

ACCOUNT #36766
TOWN OF ACUSHNET
24 RUSSELL STREET
ACUSHNET, MA 02743
PH: 508.998.0250
FAX: 508.998.5889
ORDERING PROVIDER: MATHEW BIVENS

PATIENT'S INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE

DATE OF BIRTH (M/D/Y)	GENDER ○ M ○ F	RACE	ETHNICITY

ADDRESS	APT #

CITY	STATE	ZIP	PHONE NUMBER	EMAIL
				Email address not required

BILLING INFORMATION

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

SPECIMEN COLLECTION

DATE	
TIME	☐ AM ☐ PM

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME		
ADDRESS		
CITY / STATE / ZIP		
PATIENT ID		
GROUP No #		
PATIENT RELATIONSHIP TO INSURED	☐ SELF ☐ SPOUSE ☐ DEPENDANT	☐ SELF ☐ SPOUSE ☐ DEPENDANT

Insurance information not required

RESPIRATORY PANEL

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

DIAGNOSES (ICD-10 CODES)

PHYSICIAN'S SIGNATURE _____ DATE _____

Push to clear all fields