25 N Winfield Rd - Winfield, Illinois 60190
(630) 933-2633

Laboratory Test Requisition

Lab Use Only

ADDITIONAL COPY TO (NAME):

FAX NUMBER FOR ADDITIONAL SITE:

☐ **STAT (Additional Charge)**

Patient Information: (Please Print)

Lab Bill To: * Additional Information Required

☐ My Account ☐* Medicare ☐* Patient's Insurance ☐* Medicaid ☐* Patient

Last Name	First	M.I.

Sex	Date of Birth	Social Security Number
	– –	– –

Date Collected	Time Collected	Collected by
	: am pm	

Phone number	Patient Address
( )	

Apt #	City	State	Zip Code

Patient's Relationship to Insured: ☐ self ☐ spouse ☐ dependent

Responsible Party (omit if same):

Address:

City: State: Zip:

Payment by Medicare (Attach copy of Card- front & back)

Medicare Number	Marital Status

Payment by IDPA (Attach copy of Card- front & back)

Cardholder name: **Cardholder** DOB:

Is this patient pregnant? Yes No **IF YES, DUE DATE:**

Recipient #: Case #:

Payment by Insurance (Attach copy of Card- front & back)

Insurance Name:	Group #:
Insurance Address:	Policy #:

*****Physician Signature:**________________________________

Ordering Physician(s)

Diagnosis related to ordered tests (ICD-10 codes effective 10-1-2015)

(1)	(2)	(3)
(4)	(5)	(6)

LAB COPY

FORM NO. 10656 (11/2006)