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

HEALTHLAB

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 – –

***Physician Signature:_____

Date Collected | Time Collected : ___ am pm | Collected by

Ordering Physician(s)

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 #:

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

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

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

Insurance Name: | Group #:

Insurance Address: | Policy #:

LAB COPY

FORM NO. 10656 (11/2006)