

ORDERING PHYSICIAN INFORMATION:

Ordering Physician _____ NPI # _____
Clinic Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Reporting Contact Name _____ Reporting Email _____
Reporting Fax _____ (Please note that our customary reporting delivery is by protected email.)

STATEMENT OF MEDICAL NECESSITY: This requisition constitutes an order for services. I certify the services are medically indicated and necessary and they will assist me in treating my patients.

Physician Signature: _____

PATIENT INFORMATION

Last Name, First Name _____ Date of Birth ____/____/____ M F
Address _____ City _____ State _____ Zip _____
Email _____ Phone _____ Diagnosis Codes _____

PAYMENT INFORMATION

Coppe Laboratories is a Fee-For-Service Provider. **Payment must be made in full** at the time of sample submission even when an insurance claim will be filed.

Credit Card Number _____ - _____ - _____ - _____

Exp Date _____ CW _____ Name on Credit Card _____

For an **additional \$25** fee, Coppe Laboratories will submit an insurance claim with the designated insurance carrier. Coppe Laboratories is not a Medicare provider and does not bill Medicare. (Attach copy of insurance card [front and back].)

YES, I authorize Coppe Laboratories to submit a claim with my designated insurance carrier. I understand that all insurance payments will be reimbursed to me.

Insured Party Signature _____ Date _____

TEST MENU**ARTHROPOD-BORNE DISEASE**

Powassan Virus (POWV) IgG/IgM (3008)

CHROMOSOMAL INTEGRATION/HHV-6 PCR DNA (1109)

Hair Follicle, root attached, 6-8 (preferred)

Nail Clipping, 5-10, cut near nail plate (if hair follicle is insufficient)

SPECIMEN INFORMATION

Date and time collected ____/____/____ Time _____