Coppe LABORATORIES

TEST REQUEST FORM

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

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__________