MediTech
CLINICAL SERVICES

COVID Testing Request Form

915 Busse Road
Elk Grove Village, IL 60007
Phone: (224) 209-2866
Fax:(217) 336-2413
CLIA ID# 14D2228088

Facility Information Name: Phone: Fax:

Address: City: State: Zip:

Provider Name / NPI: Phone: Fax:

Address: City: State: Zip:

Provider Signature: Date:

PATIENT INFORMATION

Last Name: First Name: M.I.:

Date of Birth: Gender: M F

Address 1: Apt #:

City: State: Zip:

Phone: Email: Ethnicity: Hispanic Not Hispanic

Race: White African American Indian American Asian Alaska Native Native Hawaiian Other Pacific Islander Other

INSURANCE INFORMATION

Medical ID:

Private Insurance Name:

Policy ID: Group ID:

Uninsured/Other:

For uninsured, please provide your SSN#:

PRIVATE PAY INFORMATION

Cash/Check:

Name on CC

CC#:

Account #:

Expiration Date: Security Code:

Signature:

TESTING INFORMATION

Diagnosis Code:

Temperature:

Collector's Signature:

Date:

SPECIMEN INFORMATION

Specimen Type/Source:

***Collection Date & Time:** ____ / _____ / _____ ___ : ___ **AM/PM**

TEST MENU

Test Panel Description:

LAB USE ONLY:

Samples received by (Initials): Notes:

Sample Type:

Date:

LABEL HERE