RIDGEWOOD DIAGNOSTIC LABORATORY
126 State Street
2nd Floor
Hackensack, NJ 07601
Phone: **973-542-2343** Fax: **201-621-6663**
CLIA No. 31D2109691

Provider: _____

Location: _____

100107827

ADULT ALLERGY REQUISITION

01/16/2019-3793369-408299-RDL1-00000078 RDL1

SPECIMEN COLLECTION

DATE: **TIME:** ☐ a.m. ☐ p.m.

Collector Name: _____

(A) Patient Information:

Last Name:_____ First Name:_____ MI:_____ Phone #:_____

SSN:_____ DOB:_____ Gender: ☐M ☐F

Address:_____ City:_____ State:_____ Zip:_____

Billing Information: **ATTACH INSURANCE INFORMATION (Including insurance company name, group #, ID #, demo sheet)**

☐ Insurance ☐ Medicare ☐ Medicaid ☐ PIP ☐ Workers Comp ☐ Self-Pay Diagnosis Code(s):_____

☐ ACAP Adult Comprehensive Allergy Panel – Testing Requires 2 Full SST Tubes

Alder	Cat Dander-Epithelium	Dog Dander	Honey Bee Venom	Nettle	Walnut
Almond	Chocolate	Dog Epithelium	Johnson Grass	Oak	White Ash
Alternaria Tenuis	Cladosporium Herbarum	Duck Feathers	June Grass	Orchard Grass	White Hickory
Aspergillus Fumigatus	Clam	Egg White	Lamb's Quarters	Peanut	White Pine
Aspergillus Niger	Cocklebur	Egg Yolk	Latex	Pecan Nut	Wild Rye Grass
Bahia Grass	Cockroach	Elm	Lobster	Pistachio	Yellow Hornet
Bermuda Grass	Common Ragweed	English Plantain	Maple	Shrimp	Yellow Jacket Venom
Brome Grass	Common Sagebrush	False Ragweed	Meadow Fescue	Sweet Vernal Grass	
Canary Grass	Cottonwood	Giant Ragweed	Meadow Foxtail Grass	Timothy Grass	
Candida Albicans	Dandelion	Glycyphagus Domesticus	Milk	Turkey Feathers	
Cashew	D-Farinae	Hazelnut	Mugwort	Velvet Grass	

☐ SBSP Sick Building Syndrome Panel – Testing Requires 2 Full SST Tubes

American Cockroach	D-Pteronyssinus	Imported Fire Ant	Onion	Rabbit Epithelium	Tyrophagus Putrescentiae
Black Pepper	Garlic	Mouse	Paper Wasp Venom	Rat	
Blomia Tropicalis	Goose Feathers	Mouse Epithelium	Parrot Feathers	Rat Epithelium	
Chicken Feathers	Hamster Epithelium	Mouse Serum Proteins	Penicillium Brevicompactum	Rat Urine	
Chili Pepper	House Dust-Greer	Mouse Urine	Penicillium Notatum	Tobacco	
D-Microceras	House Dust-Hollister	Mucor Racemosus	Pigeon Droppings	Trichoderma Viride	

☐ AFAP Adult Food Allergy Panel – Testing Requires 2 Full SST Tubes

Asparagus	Brewer's Yeast	Corn	Lettuce	Oregano	Soybean
Avocado	Broccoli	Crab	Mango	Oyster	Spinach
Baker's Yeast	Cabbage	Cucumber	Melon	Pineapple	Tomato
Banana	Casein	Flounder	Mold Cheese	Pork	Tuna
Basil	Cheddar Cheese	Ginger	Mushroom	Red Snapper	Watermelon
Beef	Chicken Meat	Gluten	Mustard	Rye	Wheat
Blue Mussel	Coconut	Green Pepper	Oat	Salmon	Whey
Blueberry	Coffee	Lamb	Orange	Sesame Seeds	Yogurt

(B) Patient Authorization

I certify that I have voluntarily provided a fresh and unadulterated specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup is accurate. Also, I consent to the analysis of the specimen accompanying this form by the laboratory and I authorize Ridgewood Diagnostic Laboratory to release the results of this testing to the authorized testing healthcare provider or facility. This is an assignment of my rights to insurance benefits. I authorize any holder of my medical information and records to release to the health care financing administration and its agents, or any insurance company any information needed to determine these benefits or the benefits payable for the related services. If applicable, I hereby authorize, RIDGEWOOD DIAGNOSTIC LABORATORY, LLC to commence arbitration and/or litigation proceedings against the appropriate insurance carrier and/or initial a complaint to the Insurance Commissioner for any reason on my behalf in order for said provider to obtain payment for services furnished to me at RIDGEWOOD DIAGNOSTIC LABORATORY, LLC. I hereby authorize my insurance benefits to be paid directly to Ridgewood Diagnostic Laboratory for services I have received. I understand that Ridgewood Diagnostic Laboratory may be an out-of-network provider with my insurer. I also understand that sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit it to Ridgewood Diagnostic Laboratory immediately. Failure to send payment within 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

I have read the ABN on the reverse. If Medicare denies the payment, I agree to pay for the identified test(s).

Patient Signature_____ Date_____

(C) Practitioner Authorization

Medicare and other payors only cover testing that is medically necessary. The undersigned affirms that the testing ordered on this requisition is medically necessary for the diagnosis and treatment of the patient for whom the testing has been ordered. I hereby authorize the above ordered laboratory test(s).

Physician Signature_____ Date_____

Print Patient Name DOB (Mo./Day/Yr.) 100107827

Print Patient Name DOB (Mo./Day/Yr.) 100107827

Print Patient Name DOB (Mo./Day/Yr.) 100107827

Print Patient Name DOB (Mo./Day/Yr.) 100107827

Print Patient Name DOB (Mo./Day/Yr.) 100107827

Print Patient Name DOB (Mo./Day/Yr.) 100107827