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

Provider: _____

Location: _____

100108277

GENERAL REQUISITION

01/16/2019-3793369-408806-RDL1-00000028 RDL1

SPECIMEN COLLECTION
DATE: TIME: ☐ a.m. ☐ p.m.
☐ URINE ☐ BLOOD
Phlebotomist 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 #)**

☐ Insurance ☐ Medicare ☐ Medicaid ☐ PIP ☐ Workers Comp ☐ Self-Pay Date of Injury/Accident: _____

Insurance Company: _____ Insurance ID: _____

DIAGNOSIS CODE:
☐ _____
☐ _____
☐ _____
☐ _____

B TEST ORDERS AND PANELS (See reverse for components), SELECT BELOW:

☐ Comp Metabolic Panel	☐ Lipid Profile Panel	☐ Male Wellness Profile	☐ Female Wellness Profile
1SST	1SST	5SST, 1LAV, 1Urine	5SST, 1LAV, 1Urine
☐ SST Albumin	☐ SST HDL	☐ SST Allergy Panel	☐ SST Allergy Panel
☐ SST Alkaline Phosphatase (ALP)	☐ SST Cholesterol	☐ LAV CBC	☐ LAV CBC
☐ SST Amylase (AST)	☐ SST Triglycerides	☐ SST Comprehensive Metabolic Panel	☐ SST Comprehensive Metabolic Panel
☐ SST Bilirubin, Total		☐ LAV ESR	☐ LAV ESR
☐ SST BUN		☐ SST Estradiol	☐ SST Estradiol
☐ SST Calcium		☐ SST Ferritin	☐ SST Ferritin
☐ SST Carbon Dioxide		☐ SST Folate	☐ SST Folate
☐ SST Chloride		☐ LAV Glyco Hgb A1c	☐ SST FSH
☐ SST Glucose		☐ SST Hep B Surface Ag	☐ LAV Glyco Hgb A1c
☐ SST Potassium		☐ SST Hep C Ab	☐ SST Hep B Surface Ag
☐ SST Protein, Total		☐ SST HsCRP	☐ SST Hep C Ab
☐ SST Sodium		☐ SST LH	☐ SST HsCRP
		☐ SST Lipid Panel	☐ SST LH
		☐ SST PSA Total	☐ SST Lipid Panel
		☐ SST Testosterone (Free & Total)	☐ SST Progesterone
		☐ SST Thyroid Panel (T3, FT4, TSH)	☐ SST Testosterone (Total)
		☐ Urine Urinalysis	☐ SST Thyroid Panel (T3, FT4, TSH)
		☐ SST Vitamin B12	☐ Urine Urinalysis
		☐ SST Vitamin D 25-OH	☐ SST Vitamin B12
			☐ SST Vitamin D 25-OH

CUSTOM PANEL/ADDITIONAL TESTS
☐ BL PT/PTT INR ☐ SST CBC/ w Diff

C 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 _____

D 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.) 100108277
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