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

GENERAL REQUISITION

BARCODE
123456789

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 AND ASSIGNMENT OF BENEFITS

I certify that I have voluntarily provided a fresh and unadulterated specimen for analytical testing. The information provided on this form and on the specimen cup label is accurate. I consent to the analysis of this specimen by the laboratory and I authorize release of my test results to the testing physician or facility. I HEREBY ASSIGN TO RIDGEWOOD DIAGNOSTIC LABORATORY LLC all of my rights and benefits under my insurance plan, including the right to pursue payment from my insurance carrier, the right to receive payment directly from my insurance carrier, and the right to file appeals, arbitration proceedings, and/ or litigation against the carrier or any other responsible entity to recover payment for the laboratory's services. I authorize and direct my insurance carrier to make payment directly to Ridgewood Diagnostic Laboratory for the services it has provided. I authorize any holder of my medical records to release any information necessary to determine the benefits payable for these services. I understand that Ridgewood Diagnostic Laboratory may be an out-of-network provider with my insurance carrier and that the carrier may send payment for the laboratory's services directly to me. If that happens, I agree to immediately endorse the insurance check and submit it to Ridgewood Diagnostic Laboratory. Failure to do so within 30 days of my receipt of any insurance check may result in collection proceedings against me and/ or notice to credit reporting agencies. **I have read the ABN on the reverse side of this form. If Medicare or my insurance carrier denies payment or makes partial payment, I agree that I am financially responsible for any unpaid charges.**

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.)
BARCODE

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

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

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BARCODE

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BARCODE

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

Advanced Beneficiary Notice

Medicare will only pay for services that it determines to be reasonable and necessary under section 1882(a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare Program standards, Medicare will deny payment for that service. Medicare usually does not pay for these tests for the reported diagnosis. By signing the Patient/Responsible Party Signature on the front of this requisition, you are confirming your agreement to assume financial responsibility for the payment of these tests.

Panel Listings

SBSP Sick Building Syndrome Panel and AFAP Adult Food Allergy

- American Cockroach
- Asparagus
- Avocado
- Baker's Yeast
- Banana
- Basil
- Beef
- Black Pepper
- Blomia Tropicalis
- Blue Mussel
- Blueberry
- Brewer's Yeast
- Broccoli
- Cabbage
- Casein
- Cheddar Cheese
- Chicken Feathers
- Chicken Meat
- Chili Pepper
- Coconut
- Coffee
- Corn
- Crab
- Cucumber
- D-Microceras
- D-Pteronyssinus
- Flounder
- Garlic
- Ginger
- Gluten
- Goose Feathers
- Green Pepper
- Hamster Epithelium
- House Dust-Greer
- House Dust-Hollister
- Imported Fire Ant
- Lamb
- Lettuce
- Mango
- Melon
- Mold Cheese
- Mouse
- Mouse Epithelium
- Mouse Serum Proteins
- Mouse Urine
- Mucor Racemosus
- Mushroom
- Mustard
- Oat
- Onion
- Orange
- Oregano
- Oyster
- Paper Wasp Venom
- Parrot Feathers
- Penicillium Brevicompactum
- Penicillium Notatum
- Pigeon Droppings
- Pineapple
- Pork
- Rabbit Epithelium
- Rat
- Rat Epithelium
- Rat Urine
- Red Snapper
- Rye
- Salmon
- Sesame Seeds
- Soybean
- Spinach
- Tobacco
- Tomato
- Trichoderma Viride
- Tuna
- Tyrophagus Putrescentiae
- Watermelon
- Wheat
- Whey
- Yogurt

Specimen Codes:

B	BL	CUL	G	GR	L	P	R	SC	SL	SST	SC	SW	PPT	U	VIAL	Y
Biopsy	Blue	Swab	Gray	Green	Lavender	Plasma	Red	Sterile Cont.	Slide	Serum Sep. Tube	Stool	Probe Tec	White	Urine	Thin Prep	Yellow