



**Red Mountain  
DIAGNOSTICS**

140 Oxmoor Blvd, Suite 140  
Homewood, AL 35209  
Office: (205)224-4490

**MOLECULAR  
DIAGNOSTIC  
REQUISITION**

**UNIQUE SAMPLE  
IDENTIFICATION**

Practice Information

Provider Information

Clinical Information

Collection Date: \_\_\_/\_\_\_/\_\_\_ Collection Time: \_\_\_\_\_

Patient Demographics

Name (Last, First): \_\_\_\_\_

MRN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Sex  M  F SSN: \_\_\_-\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

ICD-10 Codes

Physician is required to submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity. For more information, visit [www.icd10data.com](http://www.icd10data.com). Physicians should only order tests that are medically necessary for the diagnosis or treatment of a patient rather than for screening purposes.

Other (Specify): \_\_\_\_\_

Billing Information

(Please attach front and back of insurance card)

Cash Medicare Third Party Client

Insurance Co: \_\_\_\_\_

Ins Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Group No: \_\_\_\_\_ Policy No: \_\_\_\_\_

Guarantor Information if Different From Patient

Policy Holder: \_\_\_\_\_

Self  Spouse  Child  Other

DOB: \_\_\_/\_\_\_/\_\_\_

Worker's Comp Date of Injury: \_\_\_/\_\_\_/\_\_\_

SARS-CoV-2 by Nucleic Acid Amplification

Patient Authorization:

I authorize the collection of this specimen for the purposes of analytical testing and release of the results to my attending physician and staff. I authorize Red Mountain Diagnostics and/or its designees to obtain insurance and billing information and release of such information as necessary to determine and collect benefits. I understand I am financially responsible for payments should insurance be denied, partially paid, or co-payments required.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Authorized Personnel Signature

\_\_\_\_\_  
Date