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. 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: ___/___/___

Test Order

☐ Clostridium Difficile	☐ Bacterial Vaginosis	☐ Gastrointestinal PCR Panel
☐ Bordetella Species PCR	☐ Candida Vaginosis	☐ Respiratory PCR Panel W/O COVID-19
☐ Group A Strep	☐ Leukorrhea Panel (CT/NG/TV)	☐ COVID-19 PCR Test
☐ Molecular Throat PCR Panel	☐ Herpes Simplex Virus 1 and 2	☐ Coronavirus Antibody IGG/IGM
☐ Wound PCR Panel	☐ VG+ (BV, CV, STD, HSV)	☐ Urinary Tract Infection PCR Panel
		☐ Antibiotic Sensitivity

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