



A Service of Inova Alexandria Hospital

2832 JUNIPER STREET • FAIRFAX, VA 22031

Specimen Pickup - Lab Results (703) 645-6175



223040585741

Date Collected: Time Collected: Collected By: Time Centrifuged:

ATTACH INSURANCE CARDS

STAT

BILL: OFFICE PAT. INSURANCE PATIENT

PATIENT LAST NAME FIRST NAME MI SEX (M-Male F-Female) DATE OF BIRTH (mm/dd/yy) SOCIAL SECURITY # PHONE PHONE (Other) ADDRESS CITY STATE ZIP

PRIMARY BILLING PARTY SECONDARY BILLING PARTY INSURANCE CARRIER POLICY # GROUP#/ENROLLMENT CODE INSURANCE ADDRESS GUARANTOR SS# RELATIONSHIP TO PATIENT

SEND RESULTS TO: Physician's Name LAST FIRST Physician's Signature FAX TO

Table with columns: TEST NO., ADDITIONAL TESTS, ICD-9, TEST NO., ADDITIONAL TESTS, ICD-9

Table with columns: ALPHABETICAL LISTING, ICD-9, ALPHABETICAL LISTING, ICD-9, PANELS/PROFILES, ICD-9, MICROBIOLOGY, ICD-9

Insurance/HMO/PPO/POS Billing Agreement I authorize the release of any medical information necessary to review and/or process this claim for payment to INOVA REFERENCE LABORATORY. I accept responsibility for payment of services not covered, deductibles, and co-payments.

Patient or Authorized Signature:

SITE/SOURCE OF CULTURE (REQUIRED)

INTEGRATED LABEL 223040585741 DOB: Pt. Full Name: Collect Date: Time: BY:

FOR OFFICIAL USE ONLY S-SST U-Ur.Cup G-Gray Culturette R-Red U-UA Tube G-Green O&P L-Lav U-CX Tube Y-Yellow Stool B-Blue 24 Hr Urine Micro-Serum Spec Rcvd: [] On Ice [] Frozen [] Screen [] Bill

SOURCE 4 - TO REORDER CALL (800) 794-5923

IRL-A (Rev. 02/13)