87 Berdan Ave #4, Wayne NJ 07470
Phone: (973) 832-7902, Fax: (973) 832-7980

NOVALAB
Reference Medical Lab

Molecular UTI
(Urinary Tract Infection)
REQUISITION FORM

Date received:_____ Lab Accession #

1. PATIENT INFORMATION

Last Name _____ **MI** _____

First Name _____ Sex_____

Date of Birth_____ Tel #_____

Address:

_____

City State Zip

2. PHYSICIAN INFORMATION

Facility Name _____

Referring Physician _____

Medical Credentials _____ NPI _____

Address:

_____

City State Zip

Tel #_____ Fax #_____

Additional Result recipient:

Physician name:_____

Phone #_____ Fax #_____

3. SPECIMEN INFORMATION

Specimen type: ☐ Swab ☐ Urine

Collected by:_____

Date _____ Time _____

4. PAYMENT INFORMATION

☐ Bill Medicare ☐ Bill Insurance ☐ Bill Patient ☐ Bill Client

Medicare ID:_____

Name of the insurance:_____

ID # _____ Grp # _____

(Please attach copy of front and back of insurance card)

5. TEST SELECTION

Urinary Tract Infection Testing performed by RT-PCR (Please indicate the medical necessity)

☐ Painful Urination (R30.0)
☐ Frequent Urination (R35.0)
☐ Dysuria (R30.0)
☐ Chills (R68.83)
☐ Cloudy Discolored Urine (R82.99)
☐ Bloody Urine (R31.21)
☐ Weakness (R53.1)
☐ Urinary Tract Infection (N39.0)
☐ Flank Pain / Low abdominal (R10.30)
☐ Long Term Drug Therapy (Z79.899)
☐ Other _____

6. PATIENT ACKNOWLEDGEMENT

By signing this authorization, I am acknowledging that payment(s) be made on my behalf to Novalab Corp. for any services provided to me by Novalab and any subsequent test ordered by my physician. I also allow the release of any medical information necessary to process all claims. I am also aware that in some circumstances my insurer will send payments directly to me. I agree to endorse the insurance check and forward to Novalab Corp. within 30 days of receipt.

Patient Signature:_____ Date: _____

7. PHYSICIAN AUTHORIZATION

By submitting this physician order for testing at Novalab, I acknowledge the test(s) ordered are medically necessary and reasonable for the diagnosis and treatments rendered. I acknowledge only medically necessary testing should be ordered. As a provider, I acknowledge that the requested test(s) are medically necessary and a written order is contained in the patient's records. If presumptive test(s) are performed, any request for definitive testing for UTI by NAA is medically necessary for my patient. I acknowledge that this order is only for this specific patient.

I undestand and agree to the statement above. I agree to have documented medical necessity to support the ordering of tests for my patient.

Physician Signature:_____ Date: _____

For Lab use only: