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Phone: (973) 832-7902, Fax: (973) 832-7980

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: <input type="checkbox"/> Swab <input type="checkbox"/> Urine
Collected by: _____
Date _____ Time _____

4. PAYMENT INFORMATION

<input type="checkbox"/> Bill Medicare <input type="checkbox"/> Bill Insurance <input type="checkbox"/> Bill Patient <input type="checkbox"/> Bill Client
Medicare ID: _____
Name of the insurance: _____
ID # _____ Grp # _____
<small>(Please attach copy of front and back of insurance card)</small>

5. TEST SELECTION

Urinary Tract Infection Testing performed by RT-PCR (Please indicate the medical necessity)		
<input type="checkbox"/> Painful Urination (R30.0)	<input type="checkbox"/> Cloudy Discolored Urine (R82.99)	<input type="checkbox"/> Flank Pain / Low abdominal (R10.30)
<input type="checkbox"/> Frequent Urination (R35.0)	<input type="checkbox"/> Bloody Urine (R31.21)	<input type="checkbox"/> Long Term Drug Therapy (Z79.899)
<input type="checkbox"/> Dysuria (R30.0)	<input type="checkbox"/> Weakness (R53.1)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chills (R68.83)	<input type="checkbox"/> Urinary Tract Infection (N39.0)	

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 understand 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: