Client Services
Phone: (888) 203-2725
Fax: (347) 685-1909
Email: clientservices@renalytix.com

TEST REQUISITION FORM

To avoid delays, complete the entire form

ACCOUNT INFORMATION

CLINIC NAME	RENALYTIX ACCOUNT #
STREET ADDRESS	SUITE #
CITY / STATE / ZIPCODE	
PHONE NUMBER	FAX NUMBER
OFFICE CONTACT AND TITLE	
EMAIL ADDRESS	

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	
PATIENT ID # / MEDICAL RECORD #	BIRTH DATE (MM/DD/YYYY)
☐ FEMALE ☐ MALE	
STREET ADDRESS	
CITY / STATE / ZIPCODE	
DAYTIME PHONE NUMBER	EMAIL ADDRESS

RACE AND ETHNICITY

☐ WHITE ☐ [illegible] ☐ HISPANIC OR LATINO
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER

DIAGNOSIS INFORMATION

ICD-10 CODES ARE REQUIRED

ICD-10 Code/s

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BILLING INFORMATION (Choose one option and provide the necessary information)

☐ Insurance	A legible copy of both sides of insurance cards. Indicate which is primary.Testing may be delayed if not received with the sample.
☐ Self-Pay	Patient will be contacted once sample is received to complete this process and set up payment or payment plan.
☐ Client	Client Name: Client Contact:
☐ Other Third Party	Pay Source: Contact Information:

TEST REQUESTED

☐ Albumin,Creatinine, **Albumin:Creatinine Ratio,** Urine (uACR, mg/g)

AUTHORIZATION

Physician Name ______________________________ NPI Number ______________________________

Email Address ______________________________

I am a licensed medical professional. I acknowledge that the test/s requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for the test/s ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer.

Physician's Signature ______________________________ Date ____________________

SPECIMEN INFORMATION

Date Sample Collected	Time Sample Collected	Phlebotomist/Collector Name	Phlebotomist/Collector Phone Number
	☐ AM ☐ PM		