



Client Services  
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## TEST REQUISITION FORM

To avoid delays, complete the entire form

ACCOUNT INFORMATION		PATIENT INFORMATION	
CLINIC NAME	RENALYTIX ACCOUNT #	PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	
STREET ADDRESS	SUITE #	PATIENT ID # / MEDICAL RECORD #	BIRTH DATE (MM/DD/YYYY)
CITY	STATE	ZIPCODE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
PHONE NUMBER	FAX NUMBER	CITY	STATE
OFFICE CONTACT AND TITLE		DAYTIME PHONE NUMBER	EMAIL ADDRESS
EMAIL ADDRESS		RACE AND ETHNICITY	
		<input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER	
DIAGNOSIS INFORMATION		BILLING INFORMATION <small>(Choose one option and provide the necessary information)</small>	
<b>ICD-10 CODES ARE REQUIRED</b>		<input type="checkbox"/> Insurance	A legible copy of both sides of insurance cards. Indicate which is primary. Testing may be delayed if not received with the sample.
ICD-10 Code/s		<input type="checkbox"/> Self-Pay	Patient will be contacted once sample is received to complete this process and set up payment or payment plan.
_____		<input type="checkbox"/> Client	Client Name: Client Contact:
_____		<input type="checkbox"/> Other Third Party	Pay Source: Contact Information:
_____			
TEST REQUESTED			
<input type="checkbox"/> Albumin, Creatinine, <b>Albumin:Creatinine Ratio</b> , 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
_____	_____	_____	_____
	<input type="checkbox"/> AM <input type="checkbox"/> PM		



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