

## Requisition Form



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100 North Boulevard Suite 1000-88 San Antonio, TX 78232 Phone: 210.764.9900 Fax: 111

Patient:	MICKEY MOUSE	Order Date:	3/26/2024	Name:	Neighborhood Family Doctors - NS
ID:	1001	Req/Control #:	0-1-1938	Address:	100 North Boulevard San Antonio, TX, 78232
DOB:	1/1/1936	Collection Date:	3/26/2024	Phone:	210.764.9900
Race:	Black or African American	Collection Time:	03:24 PM	Provider:	Marcus Welby
Ethnicity:	Non-Hispanic/Latino	Collected By:	Florence Nightingale	NPI:	1234567891
Gender:	M			Bill Type:	Third Party
Address:	100 DISNEY ROAD ORLANDO FL 12345				
Phone:	2107649901				
Email:	test@test6.com				

Preferred Date/Time: 3/26/2024 15:26

**Albumin (SID:2205)**  
 ICD Code: a00

<p><b>Physician's Medical Necessity Notice:</b> You should only order laboratory tests that are reasonable and medically necessary for the diagnosis and treatment of your patient. Upon request, you must be able to provide documentation to support the medical necessity of the laboratory tests marked on this test request form for Auspicious Laboratory to perform.</p>	<p><b>Advanced Beneficiary Notice (ABN):</b> [For Medicare Patients Only] When laboratory tests are ordered for a Medicare patient that you believe will not be paid by Medicare, you must have the patient sign an Auspicious Laboratory ABN form signed and dated by the patient at the time of service. Otherwise, Auspicious Laboratory will charge the client for laboratory tests not covered by Medicare.</p>
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Physician's Signature -----

<p>I certify that I have voluntarily provided a specimen for analytical testing. The information provided on this form and on the label affixed to the specimen is accurate. I authorize Auspicious Laboratory Inc. to release the results of this testing to the treating physician or facility. I hereby authorize my insurance benefits to be paid directly to Auspicious Laboratory Inc. for services I received. I acknowledge that Auspicious Laboratory Inc. may be an out-of-net work provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse the insurance check and forward in to Auspicious Laboratory Inc. within 30 days of receipt. Failure to do so may result in my account being forwarded to Collections and reported to a Credit Bureau. I understand that Auspicious Laboratory, Inc. may use my specimen and testing results, development, and potential publication purposes, so long as the information has been properly unidentified pursuant to law.</p>
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Patients's Signature -----