



# TEST REQUISITION FORM

Time Stamp  
Received  
Lab Use Only

Unique Medi Tech, LLC | DBA Mammoth Dx  
23151 Alcalde Drive, Ste A2 | Laguna Hills | CA 92653 | T: (800) 790-8411  
CLIA Number: 05D0643914 • NPI: 1396837605 • Federal Tax ID: 88-3755692

Specimen ID: \_\_\_\_\_

**SPECIMEN INFORMATION** Reminder: Patient's Last Name, First Name, Collection Date and Date of Birth must be on tube labels.

Specimen Collected Performed By:	Time Collected:	Date Collected:
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**PATIENT INFORMATION** **PROVIDER INFORMATION**

Last Name	First Name	Middle Initial	Facility/ Group	Referring Physician
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Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	Date of Birth: ___/___/___	NPI Provider #:
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Mailing Address	City	State	Zip	Physician Address
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Phone	Email	City	State	Zip
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<b>Race and Ethnicity</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Pacific Islander or Native Hawaiian	<input type="checkbox"/> Race Unknown <input type="checkbox"/> Other Race: _____ <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Ethnicity Unknown	<b>User Type (LTC Facility only)</b> <input type="checkbox"/> Resident <input type="checkbox"/> Staff	Diagnostic Codes:
			Clinical Information (Date of onset/exposure, travel history, previous lab results – attach additional information)

**INSURANCE INFORMATION – Please Select on of the following payment methods (REQUIRED)**

<input type="checkbox"/> Insurance Bill <input type="checkbox"/> Account Bill <input type="checkbox"/> Patient Bill (Payment Information must be completed)  Ordering Physicians should refer to applicable National and Local Coverage Determinations for further information concerning reimbursement policy. Tests submitted for Medicare and Medicaid reimbursement must meet program requirements (ICD10-codes required) or the claim may be denied.	Bill Ordering Institution:	Bill Insurance: (Provide legible photocopy of front & back of insurance card)
	Name of Insured:	Relation to Patient:
	Insurance Company:	Member Social Security #:
	Member Group #:	Member Policy #:
	Insurance Address:	Insurance Phone:

**TEST MENU**

Test Code	Test/Panel Description	Specimen Requirement	CPT Code	Prepay Price
<input type="checkbox"/> C100	SARS-CoV-2, RT-PCR – NP	Nasopharyngeal Swab	U0003, U0005	\$135.00
<input type="checkbox"/> C120	SARS-CoV-2, RT-PCR – NS	Nasal Swab	U0003, U0005	\$135.00
<input type="checkbox"/> C300	SARS-CoV-2, Flu A, Flu B	Nasopharyngeal Swab	87636	\$150.00
<input type="checkbox"/> C400	SARS-CoV-2, Flu A/B, RSV	Nasopharyngeal Swab	87637	\$200.00

**INFORMED CONSENT** **PROVIDER INFORMATION**

By signing this document, I accept financial responsibility and am aware of the testing fees. I authorize Unique Medi Tech, LLC, (DBA Mammoth Dx) to release information received medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives. I understand Mammoth Dx may be filing an out of network claim to my insurance company on my behalf. I further understand my health plan/insurance carrier may not approve and reimburse for testing in full due to coverage limits, benefits exclusions, lack of authorization, medical necessity or otherwise. My signature indicates I acknowledge and accept full financial responsibility for all services rendered at Mammoth Dx Reference Laboratory.

**SIGN HERE:**  
 Required to process test(s) \_\_\_\_\_ DATE: \_\_\_\_\_  
**PATIENT or RESPONSIBLE PARTY'S SIGNATURE (REQUIRED)**

I attest that the requested testing is medically necessary and appropriate based on the patient's diagnosis and treatment plan. I have personally completed the diagnosis codes above to indicate the accurate diagnosis for this patient.

**SIGN HERE:**  
 Required to process test(s) \_\_\_\_\_ DATE: \_\_\_\_\_  
**Authorized Provider Signature (REQUIRED)**