REQUISTION FORM

Medlife Diagnostic Services

Phone #: (972) 925-0723
Fax#: (866) 230-5899
Email: orders@medlifediagnosticservices.com

Please send patient's demographics and copy of insurance card with requistion

Patient Information:

Patient's Last Name:	**Patient's First Name:**
Patient's Date of Birth:	**Patient's Social Security #:**
Patient's Address, City, State, Zip Code:	
Patient's Phone Number:	**Patient's Email Address:**
Patient's Gender: (Circle Male or Female) — **MALE OR FEMALE**	**Does the Patient have insurance?** (Circle Yes or No) — **YES OR NO**
Primary Insurance Provider:	**Secondary Insurance Provider:**
Member ID #: / **Group ID #:**	**Member ID #:** / **Group ID #:**

For Self Pay - Who do we contact for payment?

Contact Name:	**Contact Phone Number:**

Physician and Facility Information

Facility Name:	**Authorizing Physician's Name:**
Facility Address, City, State, Zip Code:	**Authorizing Physician's NPI #:**
Phone Number:	**Phone Number:**
Fax Number:	**Fax Number:**

MedLife Diagnostic Services: Mobile X-rays, Ekg, Echo-cardiogram, and Ultrasounds

Place and X in the box next to the ordered test and circle the L or R Site when appropriate

Xrays

	Test	Code				Test	Code				Test	Code
	Chest 1V	71010		L	R	Shoulder	73030		L	R	Hip	73510
	Chest 2V (AP& LAT)	71020		L	R	Humerus	73060		L	R	Femur	73550
	Ribs	71110		L	R	Elbow	73080		L	R	Heel	73560
	Spine: Cervical C-Spine	72040		L	R	Forearm	73090		L	R	Knee	73560
	Spine: Thoracic T-Spine	72070		L	R	Wrist	73100		L	R	Tibia/Fibula	73590
	Spine: Lumbar L-Spine	72100		L	R	Hand	73120		L	R	Ankle	73610
	Pelvis	72170		L	R	Fingers	73140		L	R	Foot	73630
	Coccyx, Sacrum	72220		ABDOMEN			74010		L	R	Toes	73660
	Facial Bones (3 view)	70150		Facial Mandible (Jaw)			70100		Other: *Please Specify*			
	Skull	70250		KUB			74000					

Ultrasounds

	Upper Extremity Arterial Doppler		Upper Extremity Venous Doppler		Abdomen Complete
	Lower Extremity Arterial Doppler		Lower Extremity Venous Doppler		Other: *Please Specify*

Cardiology

	Ekg	93005		2D Echo-cardiogram		Other: *Please Specify*

Notes:

Please complete all form fields, incomplete requisition form will delay results.

Physcian/Nurse Signature **(Required)** ______________________ **Date:** ____________

By signing this order you agree, on behalf of the patient, to authorize Reliance MedLabs/MedLife Diagnostics and their reference lab partner, to render services by collecting the samples for diagnostic testing. You also authorize Reliance MedLabs/MedLife Diagnostics and their reference lab partner, to submit claims containing your patient's private health information for the purpose of procuring payment from Reliance MedLabs and for all the laboratory services rendered. Reliance MedLabs/MedLife Diagnostics and their reference lab partner can reach out to the patient or representative for payment for service not covered by insurance.