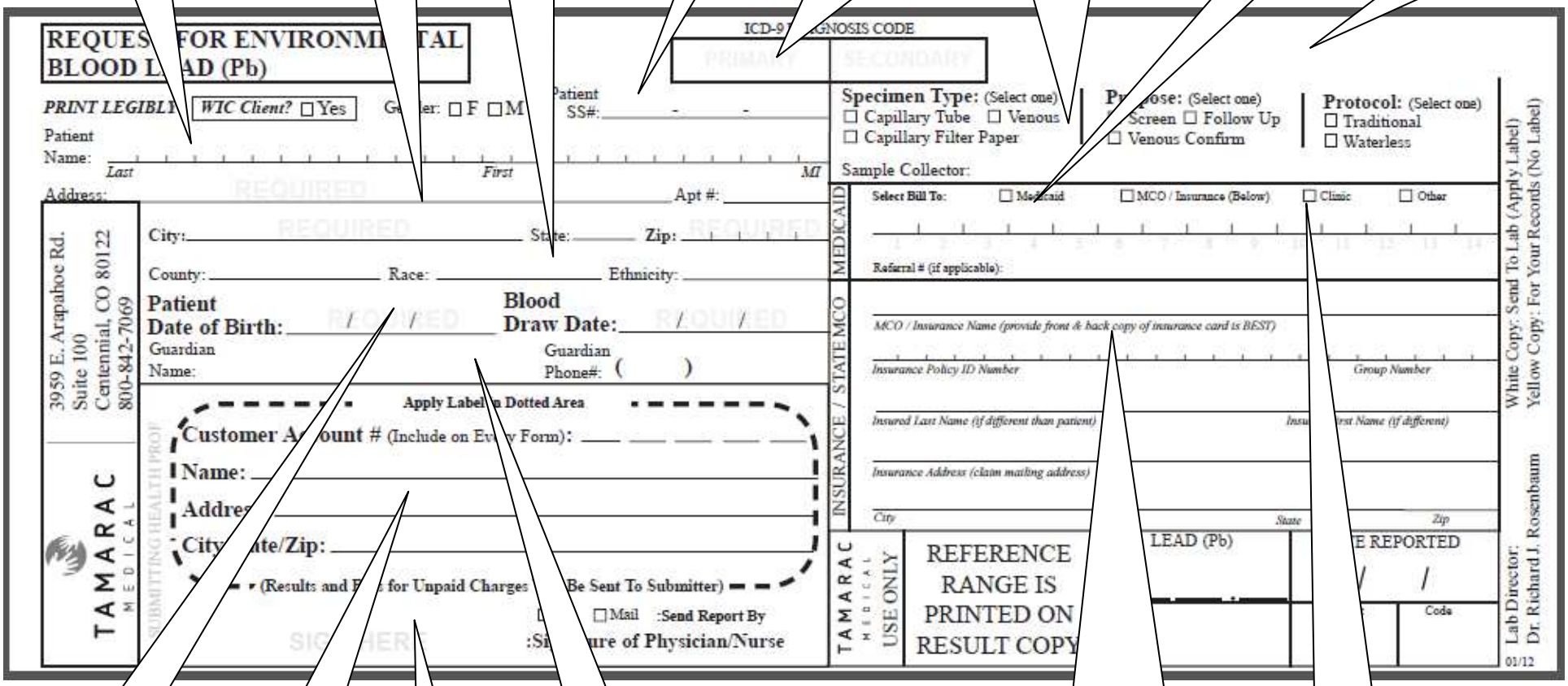

Please PRINT clearly; cursive is tough to read

Street ADDRESS, CITY, ST, and ZIP required by State CLPPP and for 3rd-party billing

Done forget RACE & ETHNICITY; required by State CLPPP

SSN generally required by State CLPPP

If known, please provide diagnosis code

Designate TYPE of specimen; PURPOSE of blood draw; and PROTOCOL used: Traditional (white kit env) or Waterless (green kit env)

If payer is "straight" Medicaid, designate here, and provide NUMBER

Test ID Barcode prints here

Date of BIRTH & Blood DRAW Date Required

Stick customer ID label with barcode here; you may write info as well; call us for labels

Physician or Nurse sign here

Guardian NAME & PHONE required by State CLPPP

If payer is MCO/Insurance, designate with check above; provide all billing info: INSURANCE CO NAME, POLICY #, GROUP #, MEMBER NAME, COMPLETE CLAIM MAILING ADDRESS (including City, ST, and Zip)

If no 3rd party payer, designate CLINIC payer (generally); no other billing info required