BILL PATIENT'S INSURANCE PROVIDER

PATIENT NAME: _____ DOB: ____/____/____

☑ **BILL INSURANCE PROVIDER *(PLEASE COLLECT PATIENT'S INSURANCE INFORMATION)***

SEND COMPLETED RESULTS TO:

PADGETT MEDICAL CENTER

6904 W Linebaugh Ave, Tampa, FL 33625

Phone: (813) 888-7710 Fax: (813) 908-7711

Dr. Jose Diaz **DEA: FD8114566** **LIC: ME122262** **NPI: 1497792162**

_____ _____

DOCTOR SIGNATURE DATE

PLEASE DISREGARD TEST CODES UNLESS USING LAB CORP

☐ **MALE**	**PLEASE DRAW THE FOLLOWING LABS**	**DX CODES**
004283	Luteinizing Hormone (LH), S	R63.5
005009	CBC with diff/platelets	R63.5
010322	PSA	
140103	Testosterone, Free and Total	R53.83
235010	Lipid Panel with LDL/HDL Ratio	
363229	CMP (14), T4, T3, TSH, CBC, FSH, Testosterone Serum, Progesterone, Estron, Estradiol	R63.5
010363	IGF-1	

Additional tests ordered _____

☐ **FEMALE**	**PLEASE DRAW THE FOLLOWING LABS**	**DX CODES**
001974	Free T4	R63.5
004283	Luteinizing Hormone (LH), S	R63.5
005009	CBC with diff/platelets	R63.5
006676	Thyroid Peroxidase (TPO) Ab	
235010	Lipid Panel with LDL/HDL Ratio	
363229	CMP (14), T4, T3, TSH, CBC, FSH, Testosterone Serum, Progesterone, Estron, Estradiol	R63.5
010363	IGF-1	

Additional tests ordered _____

I hereby authorize the release of medical information related to the services described hereon and authorize payment directly. If using my own insurance, I agree to assume responsibility for payment of charges for laboratory services that are not covered by my health care insurance. Lab Company may not accept this form without patient signature. I am responsible for contacting my insurance provider to verify that the above lab service(s) will be covered.

_____ _____

PATIENT SIGNATURE DATE

Last edited 2/6/2019