

www.wisconsinlab.com
Phone: (414) 774-8612
Fax: (414) 453-7295

Wisconsin Viral Research Group

10437 Innovation Drive
Suite 321
Milwaukee, WI 53226

Test Request Form

Enclose completed form with sample.

Rev 01-2010

I. Patient Information

Name (last, first): _____ Date of Birth: _____ M/F _____

Address: _____ Phone: _____

II. Ordering Physician Information: Please include a FAX number for result reporting

Name: _____ UPIN#: _____

Address: _____

FAX Results To: _____ Phone: _____ Contact Person: _____

III. Payment Information: Please note: Our laboratory does not bill patients, patient's insurance or Medicare**

Payment by: (choose one) Check Money Order Credit Card (fill out information below)

Name on Credit Card: _____

Credit Card Information: (circle one) VISA Master Card Discover American Express

Credit Card Number: _____ Exp Date: _____

All self-paying patients will receive a standard HCFA insurance submission form for insurance purposes.

**Medicare Advance Beneficiary Notice

These tests are not covered by Medicare unless you are an organ transplant recipient or a patient with HIV Disease. I understand that Medicare will not pay for my testing.

_____ Patient Signature

IV. Specimen Information: (circle one) Blood CSF Bone Marrow Other

Date Collected ((Required) _____ Phleb: _____

V. ICD-9 Code(s): Required (systemic complaint and/or diagnosis) 1) _____ 2) _____ 3) _____ 4) _____

VI. Tests: _____ HHV-6 Culture/Ag (#2000) _____ HCMV Culture/Ag (#3000)
_____ Nested HCMV DNA PCR (#1400) _____ Nested HHV-6 DNA PCR (#1100)
_____ Nested EBV DNA PCR (#1200) _____ HHV-7 DNA PCR (#1300)

Shipping Instructions: FedEx is our preferred shipper. Ship Monday through Thursday using the "PRIORITY OVERNIGHT - NEXT BUSINESS MORNING" shipping option.

Ship to:

Wisconsin Viral Research Group
10437 Innovation Drive
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For Lab Use Only Received: _____

Accn # _____

Mailer _____