GENESIS
REFERENCE LABORATORIES

(844) 232-7130
WWW.GENESISREFERENCELABS.COM
7924 FOREST CITY RD | SUITE 210 | ORLANDO, FL 32810

By filling out this information I am confirming that I am, in fact, uninsured at the time these services were rendered. As the patient I confirm I do not have coverage through an individual or employer-sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program. I also confirm that I am unable to afford this test at this current time. I understand the laboratory will apply through the HRSA for reimbursement for the COVID-19 test which my provider has determined is medically necessary.

All information must be provided:

Today's Date: _____/_______/_______

Last Name: ____________________________ First Name: _________________________

MI: ________ Date of Birth: _____/_______/_______ Gender: M F (Circle one)

Address: ____ *If you do not have a valid address, please enter address of site in which care was provided.*

City: _________________________________ State: ______________________ Zip: ________________

SSN#: ___________________________________

State ID/ Drivers License #: ___________________________________

A SSN and state identification / driver's license is needed to verify patient eligibility. Please understand we cannot accept claims without this information.

Patient Account Number: ____
Normally created by health care provider. EX. Medical records Number / Patient ID.

Patient Signature: ____Date :____________