



Employee Lab Registration Form

Subscriber's Employer:

____ ACL/APHL Lab

____ Provena St. Joseph Medical Center

____ Provena St. Mary Hospital

Patient Information

____ Patient First Name _____ Patient Last Name _____ Middle Initial _____ Date of Birth

____ Patient Street Address _____ Patient Phone #

____ City _____ State _____ Zip

____ I would like a copy of my report sent to the address listed above.

____ Patient's Signature is needed to release copies of reports

(Order Test Code PHI in Soft)

____ I would like a copy of report(s) for labs performed on:

____ Date(s) of Service (other than today)

Employee Information (if patient is not the policy holder) - enter as PRIV

____ Subscriber's First Name _____ Subscriber's Last Name _____ Middle Initial _____ Subscriber's DOB

____ Subscriber's Street Address (if not the same as above) _____ City _____ State _____ Zip

Insurance Information

Place HPF label here

Phlebotomist: Copy front and back of card and attach to this form. Complete info below if no copier is available.

Data Entry: ACL/APHL subscriber: Use account # 02523 with insurance code BC050.

Provena St. Joseph subscriber: Use account # 6084.

Provena St. Mary subscriber: Use account # 6083.

BC EPO ____ BC PPO ____ Blue Star EPO ____ Blue Star PPO ____ Other ____

Policy #: _____ Group #: _____

Carrier Name: _____

Carrier Address: _____

This section is to be completed by the phlebotomist

Site collecting specimen: _____
(example: Core, SACP, CP PSC)

Collection Date: _____

Specimen collected by: _____
Phlebotomist's PRINTED Name

Collection Time: _____

Phlebotomist contact #

Specimen(s) collected: _____
(example: urine cup, 2 sst, 1 lv)