CENTRAL REGIONAL PATHOLOGY LABORATORIES
2945 HAZELWOOD STREET, SUITE 310
MAPLEWOOD, MN 55109
(651) 264-1500 fax (651) 264-1646

CRPL

SPECIAL TEST/PROCEDURE ORDERS
TO BE PERFORMED AT CRPL ORREFERENCE LABORATORY

DATE: _____

PATIENT INFORMATION:

NAME: _____ DOB: _____

ADDRESS:_____

CRPL PATHOLOGY REPORT #: _____CRPL Acount # (if applicable):_____

Specimen Collection Date: _____

SPECIAL TEST/PROCEDURE REQUESTED:

_____ _____

_____ _____

ORDERING/ AUTHORIZING PHYSICIAN INFORMATION:

Clinic/Facility Name:_____

Address:_____

Phone #: _____ Fax #_____

BILLING INFORMATION (required):

☐ **Bill to patient's insurance (attach patient's current address and insurance cards)**

☐ **Bill to ordering physician at the above clinic/facility listed above**

DISCLAIMER:

I have ordered the above special test and/or procedure and I understand that the charges associated with this order may not be covered by the patient's insurance.

Denied charges will be billed directly to the ordering physician/facility. CRPL is not responsible for this test and/or procedure.

_____ _____

Ordering Physician's Name (print) Ordering Physician's Signature