REQUISTION FORM

Reliance Medlabs — Restoring Quality of Life

17774 Preston Road, Dallas, TX 75252

Medlife Diagnostic Services

Email: office@reliancemedlabs.com **CLIA#:** 45D2099319 **Phone #:** (972) 925-0723 **Fax#:** (866) 230-5899

Please send patient's demographics and copy of insurance card with requistion

Patient Information:

Patient's Last Name:	**Patients First Name:**
Patient's Date of Birth:	**Patient's Social Security #:**
Patient's Address City, State, Zip Code:	
Patient's Phone Number:	**Patient's Email Address:**

Patient's Gender: (Cirle Male or Female)	**MALE OR FEMALE**	**Does Patient have insurance? (Cirlce Yes or No)**	**YES OR NO**

Primary Insurance Provider:		**Secondary Insurance Provider:**	
Member ID #:	**Group ID #:**	**Member ID #:**	**Group ID #:**

For Self Pay - Who do we contact for payment?

Contact name	**Contact Phone Number**

Physician and Facility Information

Facility Name:	**Authorizing Physician's Name:**
Facility Address, City, State, Zip Code:	**Authorizing Physician's NPI #:**
Phone Number:	**Phone Number:**
Fax Number:	**Fax Number:**

MedLife Diagnostic Services: Mobile X-rays, Ekg, Echo-cardiogram, and Ultrasounds

Place and X in the box next to the ordered test and circle the L or R Site when appropriate

Xrays

	Chest 1V	71010		L	R	Shoulder	73030		L	R	Hip	73510
	Chest 2V (AP& LAT)	71020		L	R	Humerus	73060		L	R	Femur	73550
	Ribs	71110		L	R	Elbow	73080		L	R	Heel	73560
	Spine: Cervical C-Spine	72040		L	R	Forearm	73090		L	R	Knee	73560
	Spine: Thoracic T-Spine	72070		L	R	Wrist	73100		L	R	Tibia/Fibula	73590
	Spine: Lumbar L-Spine	72100		L	R	Hand	73120		L	R	Ankle	73610
	Pelvis	72170		L	R	Fingers	73140		L	R	Foot	73630
	Coccyx, Sacrum	72220		ABDOMEN			74010		L	R	Toes	73660
	Facial Bones (3 view)	70150		Facial Mandible (Jaw)			70100		Other: *Please Specify*			
	Skull	70250		KUB			74000					

Ultrasounds

	Upper Extremity Arterial Doppler		Upper Extremity Venous Doppler	Abdomen Complete
	Lower Extremity Arterial Doppler		Lower Extremity Venous Doppler	Other: *Please Specify*

Cardiology

	Ekg	93005	2D Echo-cardiogram	Other: *Please Specify*

Notes:

Please complete all form fields, incomplete requisition form will delay results.

Physcian/Nurse Signature **(Required)** _____ **Date:** _____

By signing this order you agree on behalf of the patient to authoirze Reliance MedLabs/MedLife Diagnostics and their reference lab partner, to render services by collect the samples for diagnostic testing. You also authorize Reliance MedLabs/MedLife Diagnostics and their reference lab partner to submit claims containing your patients private health information for the purpose of procuring payment of Reliance MedLabs and for all the laboratory services rendered. Reliance MedLabs/MedLife Diagnostics and their reference lab partner, can reach out to the patient or representative for payment for service not covered by insurance.