KIRBY MEMORIAL HEALTH CENTER

71 North Franklin Street, Wilkes-Barre, PA 18701 (570) 823-5450
www.kirbyhealthcenter.org

CLIA ID# 39D0657582 NPI# 1891787800

LEAD ANALYSIS REQUISITION FORM

(If any information is missing on this form, sample will be rejected.)

CIRCLE ONE:

Access	Highmark Wholecare	Blue Cross / Blue Shield
Aetna Better Health Kids	Geisinger Family	UPMC
AmeriHealth Caritas	UnitedHealthcare Community Plan	Physicians Office*: - Payment Enclosed
AmeriHealth Caritas Northeast	UPMC For You	- Office To Be Billed

PROVIDER INFORMATION

(Please Print)

Name of Office: _____ Telephone No.: (____) _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Fax/Email: _____

Referring Physician Signature: _____

NPI #: _____ License #: _____

ICD-10 Diagnosis Code: (check one) ☐ Z00.129 (Routine Child Health Exam) ☐ Z13.88 (Screening Due to Exposure)

PATIENT INFORMATION

(Please Print)

Patient's Name: _____ Date of Birth __/__/____
(Last) (First)

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: (____) _____ Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Other ☐ Unknown

Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown

Health Plan ID# : _____

Insurance Primary to MA: Plan _____ **ID #** _____

Screen Date: __/__/____ ☐ Finger stick ☐ Venous

☐ I authorize the release of any medical information to process the claim and request payment benefits to the party who accepts assignment.

Parent / Guardian Signature**: _____

Date: _____

FOR LABORATORY USE ONLY

DATE RECEIVED			
M	D	Y	

* Personal Checks/Credit Cards Not Accepted
** "On File" Not Acceptable

Rev. 5-1-23