# Patient Insurance Information COVID-19 Testing

Patient Name: _____ _____ Date of Birth: _____
Last First

Please select one from the three options below:

☐ **Option 1:** **Patient insurance information on file from a previous specimen.**

☐ **Option 2:** **Patient is insured.** Attach a copy of the front and back of the patient's insurance card or complete the information below:

Subscriber Name: _____

Policy Number: _____ Group Number: _____

Insurance Policy: _____

Insurance Address: _____

☐ **Option 3:** **Patient is not insured.** Please complete uninsured individual attestation below:

**Uninsured Individual Attestation**

- With sound mind and clear intent, I am representing that I am an Uninsured Individual with full knowledge that the cost of this COVID-19 testing will be paid for with funds from the Federal Health Resources & Services Administration (HRSA) COVID-19 Uninsured Program.
- I understand that falsely representing that I am an Uninsured Individual is a violation of the law and may result in criminal and/or civil legal actions against me.

**By signing and dating below, I attest as follows:**

1. As of the date of service, I am an Uninsured Individual and not enrolled in a Federal health care program; or
2. As of the date of service, I am an Uninsured Individual and not enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in a group or individual market.

_____ _____
Print Name of Uninsured Individual/Responsible Party Date

_____ _____
Signature of Uninsured Individual/Responsible Party Date

Address: _____

Social Security Number: _____

Driver License Number or Other State Issued ID: _____

**For receiver use only:**

Received by: _____

**For Medical Diagnostic Laboratories, L.L.C. (MDL) use only:**

Eligibility Checked by: _____