Line List for Commercial Laboratories to Test Community Care Facility Staff and Residents

Name of Institution: _____   Contact Person: _____   Date Completed: _____

Address: _____   Phone: _____

Patient Information					Insurance Information		Provider Information	
Last Name	First Name	MI	Phone Number	Street Address	Insurance Company	Phone Number	Full Name	Phone Number
DOB	Race/Ethnicity	Sex	County of Residence	City, Zip	Policy No.	Member No.	NPI	Provider Advanced Consent
Last Name	First Name	MI	Phone Number	Street Address	Insurance Company	Phone Number	Full Name	Phone Number
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