pathline

COVID ATTESTATION OF UNINSURED PATIENT

ATTACH THIS FORM WITH A PHOTO ID TO THE REQUISITION

FAX FORM & PHOTO ID TO (201) 282-6364
OR
EMAIL SECURELY to billinginfo@pathlinelabs.com

TO BE COMPLETED BY THE PATIENT WHEN COVID-19 TESTING IS ORDERED:

Date of Service: _____

Patient Name: _____

Date of Birth: _____

REQUIRED INFORMATION (must complete the following):

SS#:_____ **State of Residence:** _____

State Driver's License:_____ **State of Residence:** _____

I do not have health care coverage such as individual, employer-sponsored, Medicare or Medicaid coverage. Therefore, I affirm and attest the above patient qualifies as uninsured according to the COVID-19 Uninsured Program in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136).

Signature of Patient/Legal Guardian: _____ Date: _____

Relationship to Patient: _____ Self: ☐

Physician or Account Name: _____

Client Account#: _____

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