IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF PUBLIC HEALTH

Client Billing Form*

BUREAU OF LABORATORIES
2220 Old Penitentiary Road
Boise, Idaho 83712 (208) 334-2235

Date of Service: _____

Client ID #: _____ If Health District select one: 1 2 3 4 5 6 7

Patient Name: _____

Birth Date: _____ Gender: ○ M ○ F

Patient Address: _____

☐ Bill to District Medicaid #: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Insurance Address: _____

Tests to Bill: (check all tests ordered)

VDRL (Syphilis screening)	☐	Rubeola IgG Antibody	☐
Hepatitis B Surface Antibody	☐	Rubeola IgM Antibody	☐
Hepatitis B Surface Antigen	☐	Varicella Zoster IgG Antibody	☐
Hepatitis B Core Total Antibody	☐	Varicella Zoster IgM Antibody	☐
Mumps IgG Antibody	☐	Bordetella pertussis PCR	☐
Mumps IgM Antibody	☐	Measles RT-PCR	☐
Rubella IgG Antibody	☐	Mumps RT-PCR	☐
Rubella IgM Antibody	☐	Virology culture_____(please specify)	☐
Other, please specify:			☐

Label Option: if label is used, it must provide all the above information. If not, please fill in any missing information above.

* Do not send this form if the testing is surveillance or part of an outbreak investigation.

Revised 4/16/2015 http://healthandwelfare.idaho.gov/Portals/0/Health/Labs/Client_Billing_Form.pdf