



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)	<input type="checkbox"/>	Rubeola IgG Antibody	<input type="checkbox"/>
Hepatitis B Surface Antibody	<input type="checkbox"/>	Rubeola IgM Antibody	<input type="checkbox"/>
Hepatitis B Surface Antigen	<input type="checkbox"/>	Varicella Zoster IgG Antibody	<input type="checkbox"/>
Hepatitis B Core Total Antibody	<input type="checkbox"/>	Varicella Zoster IgM Antibody	<input type="checkbox"/>
Mumps IgG Antibody	<input type="checkbox"/>	Bordetella pertussis PCR	<input type="checkbox"/>
Mumps IgM Antibody	<input type="checkbox"/>	Measles RT-PCR	<input type="checkbox"/>
Rubella IgG Antibody	<input type="checkbox"/>	Mumps RT-PCR	<input type="checkbox"/>
Rubella IgM Antibody	<input type="checkbox"/>	Virology culture _____(please specify)	<input type="checkbox"/>
Other, please specify:	<input type="checkbox"/>		<input type="checkbox"/>

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.