Date: _____

HRSA COVID-19 Uninsured Program

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

State of Residence: _____ Driver License # : _____ Date of Service: _____

PMH Laboratory, Inc attest that we attempted to capture the above information prior to submitting a claim.

I certified that the above patient has no Insurance, Federal, Private, nor Medicare coverage. Patient status is uninsured.

Patient signature: _____

* Attach a copy of your photo ID (Driver License, State ID, Passport, etc.)

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