Date: _____________

HRSA COVID-19 Uninsured Program

First Name: ___________________ Middle Initial: ____ Last Name: _________________________

Date of Birth: ____________ Gender: __________ Social Security #: _________________________

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 a Government issued ID or Student ID number.

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5862 Edinger Ave. Huntington Beach, CA 92649 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com
18249 Gothard St. Unit 101, Huntington Beach, CA 92648 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com