



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 Driver License and Social Security Card.