



Sema4 COVID-19 Test Request Form

Please fill out all fields. Any field left blank can lead to a delay in testing or to the rejection of your sample

Patient Last Name

Patient First Name

Date of Birth (MM/DD/YYYY)

Biological Sex

M

F

Prefer not to answer

Email Address
(each person must have their own unique email address)

Cell Phone Number

Street Address

City and State

Zip Code

Your Occupation

Have you previously tested for COVID-19 with Sema4?

No

Yes

If yes, at which site?

Insurance Information

Policy Holder Last Name	Policy Holder First Name	Policy Holder DOB	Relationship to Policy Holder
Insurance Carrier	Insurance ID	Group No.	