MINNESOTA DEPARTMENT OF HEALTH

STAY SAFE MN

2020-2021 COVID-19 Testing Registration Form

REQUIRED INFORMATION FOR PERSON RECEIVING TEST

One registration form must be completed, in full and must be legible, for each person tested for COVID-19.
A new form is required for any repeated testing, as applicable.

It is important to provide your insurance information so that tests can be processed appropriately.
If you are uninsured, you will not be charged for this test.

Choose 1

☐ **Conducting point prevalence testing due to an outbreak, symptomatic individuals or for relaxation of visitation guidance.**

☐ **Nursing Facilities Only: Conducting serial staff testing due to CMS requirements. (Skip insurance information section)**

Facility name

Address

City | State | Zip

☐ **Resident** ☐ **Staff**

***If resident is checked, is the facility billing insurance?** ☐ **Yes** ☐ **No**

***If resident is checked, is resident under a Medicare Part A PDPM stay?** ☐ **Yes** ☐ **No**

Last name | First name

Middle name | SSN—last 4 digits | Date of birth (MM/DD/YYYY) | Age

Phone ☐ Cell ☐ Home

☐ Female ☐ Male ☐ Other

Guardian's full name | Guardian's phone number

INSURANCE INFORMATION

☐ **Person is uninsured**

Primary insurance company name

Insurance ID#

Group #

Policy holder

☐ Self (skip section below) ☐ Spouse ☐ Parent ☐ Other

Policy holder last name

First name

Date of birth (MM/DD/YYYY)

Phone ☐ Cell ☐ Home

MINNESOTA