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.	

1 Commercial Street, Branford, CT 06405
CT License # CL-0830

P: 800-298-6470, option 2 and then option 2 again
Cov2support@sema4.com