Accurate Medical Lab

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CLIA # 49D2165628

PRACTICE INFORMATION

COVID-19 TEST REQUISITION FORM

PATIENT'S INFORMATION:

Please Include a current medication list AND a patient face sheet OR complete all sections below. and Include Photocopy of insurance card (front and back).

Patient Last Name:	Patient First Name:	Biological Sex F ☐ M ☐
Date of Birth (MM/DD/YYYY)	Phone Number:	Email:
Address	City / State	Zip

Ethnicity: African American Asian Caucasian Hispanic white Other

PATIENT INSURANCE INFORMATION - Attach patient demographics and copy of insurance card

☐ Insurance ☐ Self-Pay ☐ Client Bill ☐ uninsured

Primary Insurance	Social Security Number	Primary Insurance ID#	State ID/ DL #
Name of Person Insured	Date of Birth Insured		

SPECIMEN INFORMATION*

Nasopharynx Swab Collection Date: / / Collection Time: Tech. Initial: _____

TESTS

Coronavirus Disease (COVID-19) Virus Testing

DIAGNOSIS (ICD-10) CODES

- ☐ R05 Cough
- ☐ R06.02 Shortness of Breath
- ☐ R50.9 Fever, Unspecified Pneumonia (COVID-19)
- ☐ J12.89 Pneumonia, Other viral pneumonia
- ☐ B97.29 Pneumonia, Other coronavirus Lower Respiratory Infection (COVID-19)
- ☐ J22: Acute lower respiratory infection, Unspecified
- ☐ B97.29 Pneumonia, Other coronavirus

Other: .....

- ☐ J01.90 Acute Sinusitis, Unspecified
- ☐ J02.9 Acute Pharyngitis, Unspecified
- ☐ J06.9 Acute Upper Respiratory Infection, Unspecified
- ☐ Acute Bronchitis (COVID-19)
- ☐ J20.8 Acute Bronchitis, Unspecified
- ☐ B97.29 Pneumonia, Other coronavirus
- ☐ Z03.818 Suspected exposure to COVID-19

- ☐ J18.9 Pneumonia, Unspecified Organism
- ☐ J20.9 Acute Bronchitis, Unspecified
- ☐ J32.9 Chronic Sinusitis, Unspecified Bronchitis (COVID-19)
- ☐ J40 Bronchitis, Unspecified
- ☐ B97.29 Pneumonia, Other coronavirus
- ☐ Z20.828 Known Exposure to COVID-19

DISCLAIMER FOR COVID-19

I, the undersigned patient, understand that I am financially responsible for paying the full cost of the services provided to me by Accurate Medical Lab prior to those services being rendered. I am responsible to pay $150.00 for the services. By signing this statement, I acknowledge that Accurate Medical Lab will not bill or submit a claim for payment to my healthcare insurance carrier. I understand that, after making payment in full to Accurate Medical Lab Accurate Medical Lab will provide me with an invoice and a receipt with regard to this payment. I acknowledge that it is my responsibility, and no one else to seek reimbursement from my healthcare insurance carrier for the amount that I paid to Accurate Medical Lab. I further acknowledge that Accurate Medical Lab makes no representation and/or guarantee with regard to whether the amount that I paid to Accurate Medical Lab will be reimbursed by my insurance. I understand that the amount paid by me to Accurate Medical Lab is my full financial responsibility and may not be reimbursed at all by my insurance carrier. I authorize Accurate Medical Lab to obtain my valid government ID proof for the documentation purpose.

Signature of Patient or Patient Representative / Relationship to Patient **Date:**

PROVIDER INFORMATION

As part of my antibiotic stewardship policy, I find it medically necessary to rapidly determine and differentiate a viral and/or bacterial infection in order to treat with or without appropriate antibiotics. Having the most accurate and timely data available to me directly guides my treatment and patient management. Empiric treatment and management leads to inappropriate and unnecessary antibiotic use (50% according to the CDC) and delayed diagnosis which can lead to severe consequences. Standard antibody/antigen detection is only available to detect few pathogens and comes with a high false negative rate, relatively lower sensitivity (60-70%) and specificity (80-90%). In addition, standard antibody/antigen detection requires the infection to be present for days allowing the body to make ample antibodies in order to detect. Qualitative Nucleic Acid Amplification Testing (NAAT) is far superior with sensitivities and specificities > 98% and available to detect many pathogens. In addition, NAAT has built in controls to determine if an adequate patient sample was collected and processed, therefore greatly reducing false negative results. NAAT also includes controls to easily determine a contaminated sample, therefore reducing false positive results. If the results are positive, that will be reported to Department of Health as required. I am sending one swab for both COVID-19 and RPP testing. If the repeat is necessary, a new swab will be collected from the patient.

Authorizing Provider Name	Authorizing Provider NPI#
Authorizing Provider Signature	Date

Patient Signature PATIENT CONSENT AUTHORIZATION

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to Accurate Medical Lab, its assigned affiliates and authorized representatives for laboratory services furnished to me by Accurate Medical Lab. I irrevocably designate, authorize and appoint Accurate Medical Lab or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to Accurate Medical Lab immediately upon receipt. I hereby authorize Accurate Medical Lab, its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to Accurate Medical Lab, in compliance with federal and state laws. Accurate Medical Lab, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of Accurate Medical Laboratory and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I am aware that if the result is positive, Accurate Medical Lab will report it to Dept of Health as required.

Signature of Patient or Patient Representative / Relationship to Patient Date:

Patient Questionnaire

Name: _____ Date Of Birth: / /

1- Is this patient employed in a healthcare setting with patient exposure?

☐ Yes ☐ No ☐ Unknown

2- Is this the first time this patient has been tested for COVID-19?

☐ Yes ☐ No ☐Unknown

3- Resident or work in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting)?

☐ Yes ☐ No ☐Unknown

4- Have you been in personal contact with a person infected with Coronavirus or who has traveled to an area with widespread and ongoing transmission of Coronavirus in the past 30 days?

☐Yes ☐ No ☐Unknown

5- Symptomatic as defined by CDC? (Have you had a fever, Coughing, Sore Throat, Difficulty Breathing, Muscle Aches, Stomach Pain).

☐ Yes ☐No ☐Unknown

6- The date of symptom onset for the patient. If symptomatic enter the date or enter NA if not symptomatic.

The Date: / /

7- Was this patient hospitalized at the time of specimen collection?

☐Yes ☐No ☐ Unknown

8- Have you traveled outside the U.S. in the past 30 days?

☐Yes ☐ No If yes, where? _____

9- Was this patient pregnant at the time of specimen collection?

☐ Yes ☐No ☐Unknown ☐ N/A

10- Did you contact or live with the person who was diagnosed of COVID-19 for the past 14 days

☐ Yes ☐No

Signature of Patient or Patient Representative:_____

Relationship to Patient: _____ Date:_____