LABORATORY REQUEST - COVID-19 Dx

COVID-19 Dx

AEGIS SCIENCES CORPORATION
501 Great Circle Road
Nashville, TN 37228
(615) 255-2400
CLIA#: #44D2062333

The Authorized Medical Provider must determine and provide the appropriate ICD-10 code(s) for the patient's clinical condition. Provide in the spaces below, and or by selecting from the following non-exclusive list of commonly used codes.

Diagnosis Code(s) and Billing/Insurance

- ◯ **Z11.59** Encounter for screening for other viral diseases
- ◯ **Z03.818** Encounter for suspected exposure to other biological agents ruled out
- ◯ **Z20.828** Contact with and (suspected) exposure to other viral communicable diseases
- ◯ **U07.1** COVID 19 [confirmed cases]
- ◯ **Others:** _____, _____, _____

You must enclose a copy of the front and back of the patient's or policy holder's insurance card.

◯ **Commercial** ◯ **Medicaid** ◯ **Medicare** ◯ **Uninsured**

Insurance Name: _____

Subscriber ID #: _____

Group #: _____

Clinic

#21231 Assured Health COVID 19

Requesting Provider - Please Select One

- ☐ WALTER NYABERE ☐ _____
- ☐ DIVINA BIKERI ☐ _____
- ☐ KARI STANDFUSS ☐ _____

Collector's Initials ☐☐☐ Date Collected ☐☐-☐☐-☐☐

Specimen Type:

- ◯ Nasopharyngeal Swab
- ◯ Oropharyngeal Swab
- ◯ Nasal Swab

Test Requested

☒ **#05700 - SARS-CoV-2, qPCR**

Patient Information:

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ MI: ☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sex: ☐ M ☐ F Date of Birth: ☐☐-☐☐-☐☐☐☐

Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State: ☐☐ Zip Code: ☐☐☐☐☐

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Race (select all that apply):

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Other

Ethnicity:

- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Non-Latino
- ◯ Unknown

By signing this authorization, I am authorizing Aegis to submit claims and acknowledge that payment(s) of authorized insurance benefits, including but not limited to Medicaid, Medicare, other benefits or payments shall be made on my behalf to Aegis for the services here provided to me.

Patient Signature: _____

By my signature below, I certify that I have ordered the requested test for this patient, and I have determined it to be medically necessary for the diagnosis and/or treatment of this patient.

Provider Signature: _____

The US Department of Health and Human Services **requires reporting of standardized laboratory data** to assist in clear, accurate public health decision-making. **Reporting of results will be delayed if samples are received without a barcoded, affixed label and required patient and provider information. Print clearly and legibly.**

Please ensure the following steps are completed prior to submitting a test order:

✓	Indicate proper Diagnosis Code for patient's clinical condition	✓	Add Patient Name and Date of Birth to label located at top of requisition
✓	Supply patient insurance information	✓	Peel off label and place lengthwise on specimen tube
✓	Select an ordering provider	✓	Complete Patient Information Section in its entirety
✓	Add date collected	✓	Obtain signature from ordering provider and patient

For results, visit https://patientportal.aegislabs.com

17198 Rev. C

COPY 1 - ORIGINAL - MUST ACCOMPANY SPECIMEN TO LABORATORY / COPY 2 - PROVIDER OFFICE COPY / COPY 3 - PATIENT COPY