InHealth Diagnostics, LLC dba Real Lab
CLIA # 45D2117218
Lab Director: Chester S. Gwin, III,MD

SARS-CoV-2 (COVID-19) Panel Requisition

Patient Information

First Name	MI	Last Name	DOB	Gender: ☐ Male ☐ Female

Address

City/County	State	Zip

Phone

Practice Information

Clinic Name

Physician Name

NPI

Address

City	State	Zip

Phone	Fax

Race

☐ AI = American Indian or Alaska Native
☐ A = Asian
☐ B = Black or African American
☐ PI = Native Hawaiian or Other Pacific Islander
☐ W = White
☐ O = Other
☐ U = Unknown

Ethnicity

☐ H = Hispanic
☐ NH = Non-Hispanic
☐ U = Unknown

Specimen Collection

Specimen Type: ☐ Copan Diagnostics 486C (Eswab™)	Date of Collection	Time ☐ AM ☐ PM

Patient Email

Billing Information

BILL TO: ☐ INSURANCE ☐ HSA ☐ MEDICARE ☐ MEDICAID ☐ SELF PAY

Name of Policyholder	DOB	Medicare #	Medicaid #

Relationship to Policyholder: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER _____

Insurance Company	Policy #	Group #

ICD-10 Diagnosis Codes

☐ J80 Acute respiratory distress syndrome (ARDS)
☐ J20.8 Acute bronchitis due to other specific organisms
☐ J22 Unspecified acute lower respiratory infection
☐ J12.89 Other viral pneumonia
☐ J98.8 Other specified respiratory disorders
☐ B97.29 Other coronavirus as the cause of diseases classified elsewhere
☐ R05 Cough
☐ R50.9 Fever, unspecified
☐ Z20.828 Contact with and suspected exposure to other viral communicable diseases
☐ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out

Questionnaire

State if you have the following symptoms:

1. Have you traveled internationally within 14 day? ☐ NO ☐ YES
2. Have you come into close contact within someone who has a laboratory confirmed COVID-19 diagnosis? ☐ NO ☐ YES
3. Do you have a fever (greater than 100.4°F or 38.0°C) ☐ NO ☐ YES How Long: _____

Do you have symptoms of lower respiratory illness:

4. Cough ☐ NO ☐ YES How Long: _____
5. Shortness of Breath ☐ NO ☐ YES How Long: _____
6. Difficulty with Breathing ☐ NO ☐ YES How Long: _____
7. Other: _____

Patient Consent

Billing ABN and Patient Plan Information: A completed Advance Beneficiary Notice (ABN) of coverage is required by Medicare patients who do not meet medical criteria for testing. This does not apply to specific site analyses. Insurance pre-qualifications will not be performed for these tests, unless specifically requested. All tests ordered shall be processed and billed based on payor.

Patient Acknowledgment: I am covered by insurance and authorize InHealth Diagnostics, LLC to give my designated insurance carrier(s) plan on this form and other information provided by my health care provider necessary for reimbursement. I authorize InHealth Diagnostics, LLC to inform my Plan of my test results only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to InHealth Diagnostics, LLC. I further authorized payment of benefits directly to the laboratory. I understand 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 understand that any payment I received for services rendered by the laboratory for my insurance provider should be forwarded immediately to the laboratory.

Patient consent: My signature below constitutes my acknowledgment that benefits, risks, and limitations of this testing have been explain to my satisfaction by a qualified health professional and I have received a copy of the full informed consent document. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any other time. I voluntarily agreed to genetic testing.

Patient's or Responsible Party's Signature _____ **Date** _____

Medical Necessity for Testing

This test is medically necessary for the diagnosis or detection of a disease, illness, or disorder, and these results will be used in the medical management and treatment for this patient.

The person listed as the Ordering Physician, if applicable, is authorized by law to order test(s) requested, herein, I confirm that I have provided testing information to the patient and they have consented to test.

Please check all that apply:

☐ I confirm that the above patient's test is medically necessary, and the result will be used to assess patient.
☐ I agree to allow InHealth Diagnostics, LLC to transfer the information contained in this requisition for an LMN (Letter of Medical Necessity) using the ordering physician's name as his/her signature for billing purposes, if applicable.
☐ Patient meets clinical testing criteria for the above ordered test.

Provider's Signature _____ **Date** _____