AEON GLOBAL HEALTH

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SARS-CoV-2 TEST REQUISITION

Peachstate Health Management, LLC
A Division of AEON Global Health Corp
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Sales Group/Account Manager: MediCarr 3260/3264

ACCOUNT INFORMATION

Institution Name: Primary Care Pediatrics-9861
Address: 763 Peachtree Parkway
Suite 2
Phone: (678)208-2050 **County:** Forsyth
Fax: 1(678)208-2051

Provider Name:
Primary Contact Name:
Primary Contact Phone:

PATIENT INFORMATION

Last Name:____ **First Name:**____ **DOB:**____

Gender: ☐ Male ☐ Female **Ethnicity:**____ **SSN:** XXX - XX - ____

Address:____ **City:**____ **State:**____ **Zip:**____

County:____ **Phone:**____ **Email:**____

Surgery Date:____ **Surgery Time:**____

BILLING/INSURANCE INFORMATION

☐ Client Bill ☐ Insurance ☐ Cash Pay

(Please attach a front and back copy of the patient's insurance card)

Insurance Provider:____ Group #:____ Policy #:____

SPECIMEN INFORMATION

Specimen Type:

☐ Nasopharyngeal ☐ Other:____

Collection Date:____ Time:____:____ AM / PM

Collected by:____

ICD-10 DIAGNOSIS CODE(S)

(Code descriptions on reverse side of this form.)

☐ U07.1	☐ J98.8	☐ Z11.59	____
☐ J12.89	☐ J80	☐ R05	____
☐ J20.8	☐ Z03.818	☐ R06.02	____
☐ J22	☐ Z20.828	☐ R50.9	____

TEST INFORMATION

All respiratory specimens accompanied by this form will be tested for SARS-CoV-2 using RT-PCR.
Target analytes: N, S, ORF1ab

☐ **STAT (24-48 hours)**
(On average, **24-48 hours** or less from the time specimens reach the laboratory for morning processing.)

☐ **STANDARD TAT**
(**48-72 hours** from the time specimens reach the laboratory for morning processing.)

PHYSICIAN AUTHORIZATION

I authorize the laboratory test as ordered, and affirm that it is both medically necessary and corresponds to the patient's specific diagnosis as submitted to the laboratory for testing. I understand that the ordered test is a billable event, and the patient's medical record(s) must clearly reflect my order.

Ordering Physician: X Margaret Boudreaux MD

Date:____

PATIENT CONSENT

I voluntarily consent to the collection and testing of my specimen. I understand that I am responsible for all co-pays, deductibles, and amounts not covered by my insurance. I assign to Peachstate Health Management LLC all insurance payment(s) made for any laboratory services provided to me and direct same to represent me in any grievance or appeals process relating to the payment of these laboratory services. I consent to the release of any medical records necessary to process any insurance claim(s).

Patient Signature: X____

Date:____