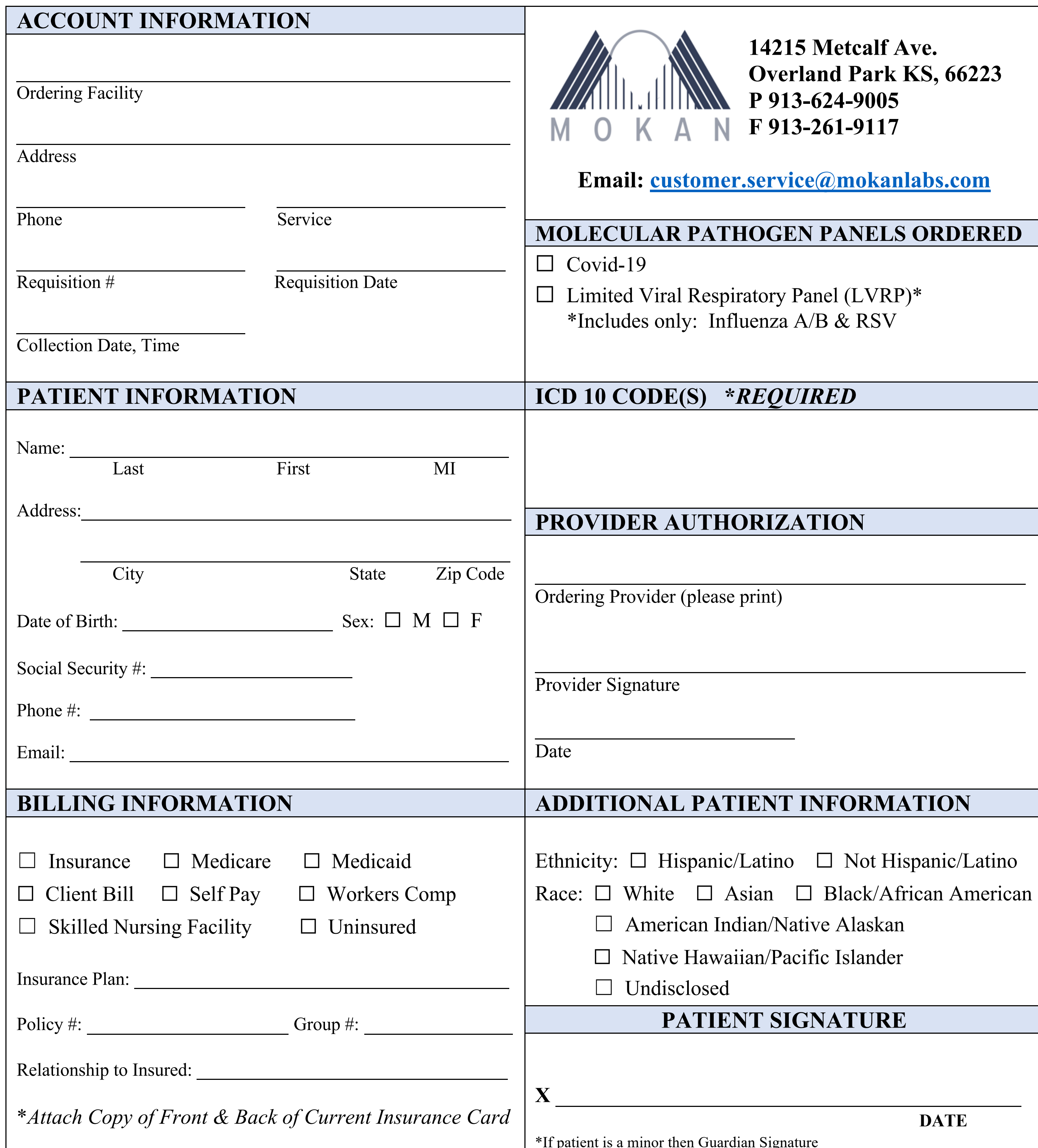
RESPIRATORY REQUISITION FORM



ACCOUNT INFORMATION

Ordering Facility: ____________________

Address: ____________________

Phone: ____________ Service: ____________

Requisition #: ____________ Requisition Date: ____________

Collection Date, Time: ____________

MOKAN

14215 Metcalf Ave.
Overland Park KS, 66223
P 913-624-9005
F 913-261-9117

Email: customer.service@mokanlabs.com

MOLECULAR PATHOGEN PANELS ORDERED

☐ Covid-19

☐ Limited Viral Respiratory Panel (LVRP)*
*Includes only: Influenza A/B & RSV

PATIENT INFORMATION

Name: ____________________
Last First MI

Address: ____________________

____
City State Zip Code

Date of Birth: ____________ Sex: ☐ M ☐ F

Social Security #: ____________

Phone #: ____________

Email: ____________________

ICD 10 CODE(S) *REQUIRED*

PROVIDER AUTHORIZATION

Ordering Provider (please print): ____________________

Provider Signature: ____________________

Date: ____________

BILLING INFORMATION

☐ Insurance ☐ Medicare ☐ Medicaid
☐ Client Bill ☐ Self Pay ☐ Workers Comp
☐ Skilled Nursing Facility ☐ Uninsured

Insurance Plan: ____________________

Policy #: ____________ Group #: ____________

Relationship to Insured: ____________________

**Attach Copy of Front & Back of Current Insurance Card*

ADDITIONAL PATIENT INFORMATION

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Asian ☐ Black/African American
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Undisclosed

PATIENT SIGNATURE

X ____________________
DATE

*If patient is a minor then Guardian Signature

Release and Consent
As a courtesy, Mokan Labs, LLC makes every reasonable effort to obtain reimbursement for ordered tests. I authorize Mokan Lab, LLC to release to Medicare, its carriers, and any insurance carrier or health plan providing benefits to me, any information that may be needed for claim purpose. By authorizing the test, I hereby assign to Mokan Labs, LLC all Medicare, Medicaid, and/or insurance benefits related to ordered tests. I understand if my insurance company pays me directly for services rendered by Mokan Labs, LLC, I am responsible for forwarding any and all such payments directly to Mokan Labs, LLC. I also understand and agree to that I am responsible for any copayment and/or deductible, as required by my plan. In addition, I understand and agree that if for any reason the ordered and performed tests are excluded from coverage by Medicare, Medicaid, or other insurance, I am financially responsible for payment to Mokan Labs, LLC.