MicroGenDX
NEXT-GEN DNA SEQUENCING FOR ACCURATE MICROBIAL IDENTIFICATION
Superior Diagnostics. Targeted Treatments. Better Outcomes.
IN ASSOCIATION WITH SOUTHWEST REGIONAL PCR LABORATORY, LLC

2002 W LOOP 289, SUITE 116 | LUBBOCK, TX 79407 | PHONE: (855) 208-0019 | FAX: (407) 204-1401

☐ PREPAID
☐ INVOICE (UNDER CONTRACT)
☐ CHARGE MEDICARE, MEDICARE ADVANTAGE, MEDICAID OR TRICARE

ORDER# XXXX

COVID-19 LAB REQUISITION FORM

ALL HIGHLIGHTED AREAS MUST BE COMPLETED PRIOR TO SENDING FORM TO LAB.

Pre-Surgery Sample? ☐ Yes ☐ No

PATIENT INFORMATION

Name (First and Last): **(Include Face Sheet)**

DOB:

Race: ☐ Asian ☐ American Indian ☐ Black ☐ Pacific Islander ☐ White ☐ Other

Gender:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Last 4 SSN: | Patient Phone: | County:

Address:

City: | State: | Zip:

ORGANIZATION INFORMATION

Organization Name:

Organization ID:

Organization Address:

City: | State: | Zip:

Organization Phone:

Patient Email:

PHYSICIAN INFORMATION

☐ Physician Name: _____ NPI#:

☐ Physician Name: _____ NPI#:

☐ Physician Name: _____ NPI#:

☐ Physician Name: _____ NPI#:

☐ Physician Name: _____ NPI#:

☐ Physician Name: _____ NPI#:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Patients first COVID-19 test? ☐ Yes ☐ No

Is Patient pregnant? ☐ Yes ☐ No

Is Patient hospitalized? ☐ Yes ☐ No

Is Patient in ICU? ☐ Yes ☐ No

Is Patient employed in the healthcare Industry? ☐ Yes ☐ No

Symptomatic as defined by the CDC? ☐ Yes ☐ No (If yes, then date of symptom onset): _____

Resident 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

SPECIMEN INFO

Date Collected: _____/_____/_____

Specimen Source:

Number of Samples:

INSURANCE & DIAGNOSTIC INFORMATION (SEND FRONT & BACK OF INSURANCE CARD)

Primary Insurance:

Subscriber ID:

Group Number:

Primary Diagnosis/Clinical Diagnosis:

Secondary Diagnosis/Clinical Diagnosis:

Medicare Claim Number:

ICD-10 Code:

ICD-10 Code:

qPCR RAPID SCREENING TEST

☑ SARS-CoV-2 (COVID-19)

This laboratory developed test is intended for the detection of SARS-Cov-2 (COVID-19) by reverse trascriptase real-time PCR on appropriate collected nasal swab, sputum, saliva and bronchial alveolar lavage. It is important to emphasize the use of this test as part of a comprehensive patient evaluation, including clinical and epidemiological criteria for the diagnosis of COVID-19, as recommended by the CDC guidelines. This test DOES NOT identify Coronaviruses other than SARS-CoV-2 or other respiratory viruses or bacteria. It is recommended that Patients Under Investigation (PUI) for COVID-19 are communicated to the facility's Infection Control Department and/or the local County Public Health Department where the patient is being treated.

PHYSICIAN SIGNATURE

The test ordered is medically necessary for the diagnosis indicated. By signing the requisition, I certify that I have informed consent from the patient as required by any applicable state or federal laws with respect to each test ordered. If the patient signature is not located below, it is indicated that the physician has obtained informed written consent.

☑ **No Signature Required (Signature on File)** ☐ **Physician Signature:** _____

STOP BEFORE SENDING PLEASE HAVE PATIENT READ & SIGN BELOW

Patient Acknowledgment and Authorization for Insurance Billing and Report Release: I hereby authorize MicroGenDX to furnish my designated insurance carrier with the information on this form if necessary for reimbursement. I also authorize benefits to be payable to MicroGenDX. If my insurer pays me directly, I agree to endorse the check and forward it to MicroGenDX within five days of receipt. I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original. Self-pay charges are $99 per COVID-19 qPCR test. By signing below, I take financial responsibility for the payment for this testing.

PATIENT SIGNATURE HERE: _____