COVID-19 Molecular Test Requisition

▶ ALL YELLOW FIELDS ARE REQUIRED

PATIENT INFORMATION

First Name		Last Name	
Date of Birth / /	Sex	Age	MBI/SSN/ID#

Race ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Ethnicity ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

Address

Address	County	
City	State	Zip
Date of Collection / /	Phone #	

Email Address

CLIENT INFORMATION

Does the patient work in the healthcare field? ☐ Yes ☐ No

Is the patient a 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 shelters, foster care or other setting)? ☐ Yes ☐ No

BILLING INFORMATION

Attach the Following: ▪ Copy of Front and Back of Insurance Card, if Applicable

Payor ☐ Medicare Part A or B? ____ ☐ Insurance ☐ Patient ☐ Client ☐ Other ____________________

Pre-authorization Code

Place of Service
Required for Medicare and Insurance Plans

☐ Hospital Inpatient (POS 21)* *Facility Name* ____________________
☐ Hospital Outpatient Clinic (POS 22)* *Facility Name* ____________________
☐ Outpatient Off Campus (POS 19)* *Facility Name* ____________________
☐ Other ____________________

☐ Ambulatory Surgery Center (POS 24)
☐ Physician Office (POS 11)
***Hospital Discharge Date** _____/_____/________

INSURANCE INFORMATION

Insurance Carrier	Policy #/Insured ID #	Group #
Claims Address	Claims Phone #	Policy Holder's Name
Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent	Policy Holder's DOB / /	Policy Holder's Sex ☐ M ☐ F
Secondary Insurance (if available)	Policy #/Insured ID #	Group #

CLINICAL HISTORY Also attach copy of doctor's notes/clinical history

☐ Symptomatic patient with *confirmed/possible* exposure (list symptoms below)
☐ Asymptomatic patient with *confirmed/possible* exposure
☐ Screening for pre-op testing (list any signs and symptoms below)
☐ Personal history of COVID-19 (list any signs and symptoms below)

Check all symptoms: ☐ Fever ☐ Chills ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Fatigue ☐ Muscle aches ☐ Body aches ☐ Headache ☐ New loss of taste or smell ☐ Sore throat ☐ Chest congestion ☐ Runny nose ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Other (including ICD codes) ____________________

Other reason(s) for testing ____________________

(ICD guidelines indicate that U07.1 should only be used for a positive test result or if the patient had a previous positive result and is being retested.)

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown Is the patient currently hospitalized? ☐ Yes ☐ No Is the patient currently in an ICU? ☐ Yes ☐ No ☐ Unknown

SPECIMEN INFORMATION

Swab ☐ Nasopharyngeal Swab ☐ Oropharyngeal Swab ☐ Other ______________

Collection Media ☐ Viral Transport Media, such as UTM® or UVT® ☐ Sterile Saline

TESTING

V2.0 SARS-CoV-2 RT-PCR Test ☐ Initial Test ☐ Follow-up Test

REQUIREMENTS

Volume 1 mL

Shipping and Storage

- Multiple swabs from the same patient can be combined in a single vial for testing
- Store at 2–8° C and ship overnight on ice pack, or store frozen at -70° C and ship overnight on dry ice
- Do not leave specimen refrigerated more than 72 hours after collection
- Do not use calcium alginate tips, swabs with preservatives, or cotton swabs with wood shafts
- Label specimen container with patient first and last name and DOB
- Each specimen transport vial should be submitted with its own separate requisition and transported in its own sealed bag

Ordering clinician should enter the signs, symptoms and ICD-10 code(s) that best describes the reason(s) for performing the test.

Clinicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that is medically necessary for the diagnosis and treatment of patient.

▶ Clinician Signature (Required) ____________________

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