"Large Enough to Serve You, Small Enough to Know You".

900 Town Center Drive Suite H-50
Langhorne, PA 19047
CLIA# 39D1099562
Telephone: 267.212.2000
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PRACTICE INFORMATION

COVID-19 TEST REQUISITION FORM

PATIENT INFORMATION - IMPORTANT - Include a current medication list AND a patient face sheet OR complete next two sections below and include photocopy of insurance card (front and back).

Patient First Name	Patient Last Name	Biological Sex ☐ F ☐ M
Date of Birth (MM/DD/YYYY)	Date of Death (if applicable)	Phone Number / Email

Address	City	State	Zip

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other

PATIENT INSURANCE INFORMATION - Attach patient demographics and copy of insurance card

☐ Insurance ☐ Self-Pay ☐ Client Bill

Primary Insurance	Social Security Number	Primary Insurance ID#	Primary Insurance Group
Name of Person Insured	Date of Birth Insured		

SPECIMEN INFORMATION*

Respiratory

☐ Nasopharynx Swab

TESTS

☐ **Coronavirus Disease (COVID-19) Virus Testing**

DIAGNOSIS (ICD-10) CODES

- ☐ R05 Cough
- ☐ R06.02 Shortness of Breath
- ☐ R50.9 Fever, Unspecified
- ☐ Pneumonia (COVID-19)
  J12.89 Pneumonia, Other viral pneumonia
  B97.29 Pneumonia, Other coronavirus
- ☐ Lower Respiratory Infection (COVID-19)
  J22: Acute lower respiratory infection, Unspeci?ed
  B97.29 Pneumonia, Other coronavirus
- ☐ J01.90 Acute Sinusitis, Unspecified
- ☐ J02.9 Acute Pharyngitis, Unspecified
- ☐ J06.9 Acute Upper Respiratory Infection, Unspecified
- ☐ Acute Bronchitis (COVID-19)
  J20.8 Acute Bronchitis, Unspecifed
  B97.29 Pneumonia, Other coronavirus
- ☐ Z03.818 Suspected exposure to COVID-19
- ☐ J18.9 Pneumonia, Unspecified Organism
- ☐ J20.9 Acute Bronchitis, Unspecified
- ☐ JJ32.9 Chronic Sinusitis, Unspecified
- ☐ Bronchitis (COVID-19)
- ☐ J40 Bronchitis, Unspeci?ed
- ☐ B97.29 Pneumonia, Other coronavirus
- ☐ Z20.828 Known Exposure to COVID-19
- ☐ Other:

PROVIDER INFORMATION

As part of my antibiotic stewardship policy, I find it medically necessary to rapidly determine and differentiate a viral and/or bacterial infection in order to treat with or without appropriate antibiotics. Having the most accurate and timely data available to me directly guides my treatment and patient management. Empiric treatment and management leads to inappropriate and unnecessary antibiotic use (50% according to the CDC) and delayed diagnosis which can lead to severe consequences. Standard antibody/antigen detection is only available to detect few pathogens and comes with a high false negative rate, relatively lower sensitivity (60-70%) and specificity (80-90%). In addition, standard antibody/antigen detection requires the infection to be present for days allowing the body to make ample antibodies in order to detect. Qualitative Nucleic Acid Amplification Testing (NAAT) is far superior with sensitivities and specificities > 98% and available to detect many pathogens. In addition, NAAT has built in controls to determine if an adequate patient sample was collected and processed, therefore greatly reducing false negative results. NAAT also includes controls to easily determine a contaminated sample, therefore reducing false positive results. If the results are positive, that will be reported to Department of Health as required.

Authorizing Provider Name	Authorizing Provider NPI#
Authorizing Provider Signature	Date

STOP **Patient Signature** **PATIENT CONSENT AUTHORIZATION**

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to Genesis Diagnostics, its assigned affiliates and authorized representatives for laboratory services furnished to me by Genesis Diagnostics. I irrevocably designate, authorize and appoint Genesis Diagnostics or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to Genesis Diagnostics immediately upon receipt. I hereby authorize Genesis Diagnostics, its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to Genesis Diagnostics, in compliance with federal and state laws. Genesis Diagnostics, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of Genesis Diagnostics Laboratory and for all the laboratory services. I understand the 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 am aware that If the result is positive, GenesisDx will report it to Dept of Health as required.

Signature of Patient or Patient Representative / Relationship to Patient   Date: