Capital Diagnostics

MOLECULAR LABORATORY REQUISITION

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CLIA# 21D2076584

ACCOUNT INFORMATION

The ordering physician must sign his/her name and indicate the date the test is ordered. The signature constitutes as a certification that with respect to tests reimbursed by Medicare, Medicaid, or other third-party payers that the testing is medically necessary, and the results will be used in the management of the patient.

x_____

Physician Signature **Date**

☐ Call results to: ( ) ☐ Fax results to: ( )

PATIENT INFORMATION

Last Name First Name

DOB (MM/DD/YY) Sex ☐ M ☐ F

Phone

Insured Address

City State Zip

INSURANCE INFORMATION

☐ **Client Bill** ☐ **See Attached Insurance Forms**

Insured's Name (If different from Patient)

Primary Insurance Name & Plan

SPECIMEN INFORMATION

Address

Policy ID # Group/Plan #

☐Cash ☐Check Received by:_____

SPECIMEN INFORMATION

Date Collected ___/___/___ Time: ____ : ____ AM PM Collector:_____

Specimen Source: ☐ Nasopharyngeal Swab ☐ Urine Cup

Special notes for lab:_____

TEST SELECTION

☐ **SARS-CoV-2** *(COVID-19 only)*
☐ **Respiratory Combo** *(SARS-CoV-2, Influenza A, Influenza B, and RSV)*
☐ **Urinary Tract Panel** *(Pathogens & Antibiotic Resistances)*
Acinetobacter baumanni,Bacillus Atrophaeus,Candida albicans, Candida glabrata, Enterobacter cloacae, Enterococcus faecalis, Enterococcus faecium, Escherichia coli, Klebsiella aerogenes, Klebsiella pneumoniae, Morganella morganii, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Pseudomonas aeruginosa, Serratia marcescens, Staphylococcus aureus, Streptococcus agalactiae, Ureaplasma urealyticum, DfrA, MecA, QnrA_S, SuL1_2, VanA_C

DIAGNOSIS CODES

☐ Z03.818 POS EXP COVID-19
☐ Z20.828 CONF EXP COVID-A9
☐ R05 COUGH
☐ R06.02 SHORTNESS OF BREATH
☐ R07.0 SORE THROAT
☐ R43.9 LOSS OF SMELL/TASTE
☐ R43.82 FATIGUE
☐ R50.9 FEVER UNSPECIFIED
☐ U07.1 2019-NCOV ACUTE RESP DISEASE
☐ N39.0 URINARY TRACT INFECTION

ICD 10 CODES Please enter diagnosis code(s) in the box

PLEASE NOTE: This resource is provided for informational purposes only and does not guarantee that billing codes will be appropriate or that coverage and reimbursement will result. Providers should consult with their payers for all relevant coverage coding and reimbursement requirements. It is the sole responsibility of the provider to select proper codes. This resource is not intended as legal advice or a substitute for a provider's independent professional judgment. Capital Diagnostics LLC, assumes no liability for the results or consequences associated with the use of this quick reference guide and makes no representation, warranty, or guarantee as to the accuracy or validity of any of the information contained herein. For comprehensive coding guidance see complete ICD-10-CM code set and Official Coding Guidelines, 2017 edition.

PATIENT CONSENT

PATIENT CONSENT REIMBURSEMENT: Capital Diagnostics will make every reasonable effort to obtain reimbursement for the ordered tests above. I hereby authorize CD to release to Medicare and/or any insurance carrier providingmedical benefits to me and any health plan to which I am a member any and all medical or other information necessary for claims purposes. I hereby authorize payment of medical insurance benefits to the party who bills for these claims and accepts assignments. I understand that if my insurance company pays me directly for the services provided by CD that I am responsible for forwarding such payment to CD. I understand that I am responsiblefor any outstanding balances, deductible/co-payments as required by my plan. By signing this I have read all of the above and understand it. Medicare Advance Beneficiary Notice: I have read the ABN on the bottom of thisfrom. If Medicare denies payment, I agree to pay for the identified test(s). I understand that CD may use my specimen and any testing performed on that specimen, for research, development, and potential publication purposes, so long as the information has been properly de-identified pursuant to law.

Patient Name (please print) **Patient Signature** Date

IMPORTANT MEDICARE INFORMATION TO THE BENEFICIARY: ADVANCED BENIFICIARY NOTICE (ABN)

Your physician may sometimes order laboratory testing that he or she believes to be necessary for your care, but which does not quality for coverage under your Insurance Provider's and Medicare's standards. Insurance Providers and Medicare will only pay for services that it determines to be "reasonable and necessary" based upon the diagnosis information furnished to Capital Diagnostics by your physician. If, under your Insurance Provider's and Medicare's standards, your diagnosis does not support the testing ordered, your Insurance Providers and Medicare will deny coverage. In those cases where your Insurance Providers and Medicare denies coverage, the billing will be forwarded to you, and you will be responsible for the cost of the laboratory tests