SARS Cov-2 REQUISITION FORM

(Viral RNA, Antibody Testing)

Practice Information

1. PATIENT INFORMATION

Last Name ____________________

First Name ____________________

MI ____________

Sex: ☐ F ☐M DOB ___/___/_____ Resides: ☐Home ☐Facility

Name of Facility: ☐N/A ____________________

Address: ____________________

City, State, ZIP: ____________________

Facility Contact Person: ____________________

Facility Contact Phone: ____________________

2. PAYMENT INFORMATION

BILL: ☐ Patient ☐ Insurance ☐ Other

☐See attached copy of patient demographics/insurance info

Primary Insured Name:

Relationship to insured: ☐Self ☐Spouse ☐Child ☐ Other

Insurance Company: ____________________

Member ID# ____________Group ID# ____________

City, State, ZIP: ____________________

☐No Fault, Workers Comp Claim # ____________________

Adjuster Name: ____________ Phone# ____________

Date of Injury ___/___/_____ Body Part: ____________

4. SCREENINGS AND PANELS

COVID 19

☐ RT-PCR Real time polymerase chain reaction (RT-PCR)

☐ IgG/IgM Rapid Test

3. SPECIMEN COLLECTION

Date of Collection:__________ Time:_______ ☐AM ☐PM

Collected by: ____________________

☐ Nasopharyngeal swab

☐Blood (Finger stick)

5. ICD-10 Codes

☐ Z03.818 possible exposure to COVID 19
☐ Z20.828 actual exposure COVID 19
☐ B99.9 Unspecified Infectious Disease
☐ J06.9 Acute Upper Respiratory, Unspecified
☐ J00 Acute Nasopharyngitis
☐ J22 Acute Lower Respiratory
☐ J01.90 Acute Sinusitis, Unspecified
☐ J98.9 Respiratory Disorder, Unsp Unspecified
☐ J02.9 Acute Pharyngitis, Unspecified
☐ R05 Cough
☐ R50.9 Fever, unspecified
☐ Z57.9 Occupational exposure to unspecified risk factor

6. RESULTS

RESULTS SENT TO: (SELECT ALL THAT APPLY)

☐Physicians Portal ☐ Fax

7. PATIENT AUTHORISATION

I authorize Suretox to release the results of this testing to the treating authorized health care provider or facility. I hereby authorize my insurance benefits to be paid directly to Suretox for services I received. I understand that Suretox may be an out-of-network provider with my insurer. I also understand that in sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit to Suretox immediately. Failure to send payment with 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

Patient Signature: Date:

8. PHYSICIAN SIGNATURE

I authorize the above ordered test(s)

Provider Signature:

Date:

Pt.Name ____________

Date_______DOB_______

BAR CODE//////////

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