NxGen MDx

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COVID-19 (SARS-COV-2 VIRUS) TEST REQUISITION FORM

NXGEN USE ONLY

Patient Information

First Name_____ Middle Initial_____

Last Name_____

DOB(MM/DD/YYYY) _____/_____/_____ Biological Sex ☐ M ☐ F

Tel #_____

Current Address_____

City_____ State_____ Zip_____

Patient Questionnaire

Required for Federal CARES Act compliance

☐ No ☐ Yes Is the patient symptomatic of COVID-19?

Symptom Onset Date _____/_____/_____

☐ No ☑ Yes Does the patient work in a healthcare setting?

☑ No ☐ Yes Does the patient reside in congregate care?

☐ No ☐ Yes Is the patient hospitalized?

☐ No ☐ Yes Was the patient admitted to an ICU?

☐ Yes ☐ No Is this the patient's first COVID-19 test?

Race_____ ☑ Hispanic ☑ Not Hispanic

Ordering Clinician Information

ACCT# 202285GMI
Schoolcraft Memorial Hospital Rural Health Clinic
7870W US Highway 2
Manistique, MI 49854
P:906-341-2153 F:906-341-3299
Jeffrey Bomber, DO

1. Place one specimen barcode label lengthwise on the sample tube
2. Place second barcode label here or write below

Specimen Barcode ID_____

Specimen Collection Date _____/_____/_____

Provider Signature*:_____
*Acknowledgments on backpage

Swab Type: ☐ **Nasopharyngeal** ☐ **Oropharyngeal** ☐ **Nasal** ☐ **Mid-Turbinate**

☐ **Reflexive Testing** *Test for Respiratory Pathogen Panel if negative for COVID-19*

ICD-10 Codes:

☐	Z20.828	Known exposure to COVID-19	☐	R06.02	Shortness of breath	☐	R53.83	Fatigue
☐	R05	Cough	☐	R50.9	Fever	☐	R51	Headache

Other ICD-10 Codes:_____

Billing Information

☐ **Client Bill**

☐ **Patient Insurance** *Please complete below or attach copy of insurance card to this form.*

Insurance Company_____

ID#_____ Group#_____ *(if applicable)*

☐ **No Insurance**

Social Security #: _____-_____-_____ or State ID #/ Drivers License #: _____ State:_____

A social security number, state of residence, and driver's license number/state identification number is needed to verify patient eligibility. If this information is not submitted, you will need to attest that you attempted to capture this information before submitting a claim and that the patient did not have this information at the time of service. Claims submitted without the necessary information may take longer to verify and will be billed to the client at $100 per test.

☐ I have confirmed the patient is uninsured. I have verified that the patient does not have individual, employer-sponsored, or Medicare or Medicaid coverage and that no other payer will reimburse you for this testing and/or treatment.

Patient Signature*:_____ Date_____/_____/_____
*Acknowledgments on backpage

Acknowledgments on backpage

Patient Acknowledgment:

I authorize the laboratory to provide my health plan with the information on this form and other information provided by my health care provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits from the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its administrators, with respect to their handling or resolution of my insurance claim.

I understand that in certain circumstances, the laboratory is required to report test data to relevant state public health agencies.

I agree that my de-identified specimen and test data (where information that could link me to the specimen or data has been removed, making it unlikely that I could be identified) may be retained, used and disclosed for research and/or to help develop products or services, in compliance with applicable laws.

I understand that I will not receive any royalties, payments, benefits or rights from any resulting products or discoveries, and that if I do not want my de-identified specimen and test data to be retained, used or disclosed for research or product development purposes I should call Customer Service at 1-855-776-9436.

Provider Acknowledgment:

I hereby confirm that the information has been provided as best as is possible. Any missing information was not available to me, the health care provider, at the time of service. The information has been provided to the patient about the test(s) to be performed and the patient has given consent for the test(s) to be performed, as required by applicable law. The testing ordered is medically necessary and has been documented in the patient's medical record. I confirm that the person listed as the Ordering Clinician is authorized by law to order the test(s) requested herein.