Virant Diagnostics, LLC

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Collection Date: _ _ / _ _ / _ _ _ _ Collection Time: _____

Place Barcode Label Here

COVID-19 Test Requisition Form

PATIENT INFORMATION

☐ Healthcare Worker:	☐ First COVID-19 test	Date of Symptom Onset:
Last Name:	First Name:	Date of Birth:
Email:	Phone:	Gender: ☐ M ☐ F
Address: City: State: Zip:	Race/Ethnicity: ☐ Hispanic/Latino ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other	

Diagnosis or Reason for Test (ICD-10 codes/Z-codes):

☐ Z20.822: Contact with and (suspected) exposure to COVID-19
☐ Z03.818 Encounter or observation for suspected exposure to COVID-19
☐ R34.1 Disturbance in smell
☐ R06.02 Shortness of breath
☐ R05 Cough
☐ R50.9 Fever
☐ B97.21 SARS-associated virus as the cause of disease
☐ U07.1 SARS-CoV-2 Acute respiratory disease
☐ R68.83 Chills (without fever)
☐ B34.2 Coronavirus infection, unspecified
☐ J06.9 Acute respiratory infection
☐ R06.89 Other abnormalities of breathing
☐ R07.1 Chest pain on breathing
☐ R07.1 Abnormal sputum
☐ R53.82 Chronic fatigue

BILLING: INSURANCE AND PAYMENT INFORMATION

☐ Bill Insurance - **Attach Copy of Insurance Card (Front & Back)** ☐ Bill Client ☐ Patient Self-Pay ☐ Other

Insurance Provider:	Name of Policy Holder:	
Policy Number:	Group Number:	
Address:	City:	State: Zip Code:

PATIENT CONSENT/AUTHORIZATION

I hereby authorize the release of medical information related to this service for submission of personalized reports to my healthcare providers and insurance carriers. In addition, I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

No tests other than those authorized shall be performed on the biological sample and the sample shall be destroyed at the end of the testing process or not more than sixty (60) days after the sample was taken, unless a longer period of retention is expressly authorized in a consent form.

Patient Signature: _____ **Date:** _____

HEALTHCARE PROVIDER INFORMATION AND AUTHORIZATION

Healthcare Provider:	NPI:	Address:
Date of Request:	Test Authorized By:	
Office Phone:	Office Email:	City: State: Zip:

I hereby authorize testing for this patient. I have supplied information regarding testing and the patient has given consent for testing to be performed. I certify that the ordered test is reasonable and medically necessary for diagnosis, care, and treatment of this patient's condition. I also authorize Virant Diagnostics, LLC to send on my behalf test results to the patient's third-party payer in connection with an appeal of a reimbursement denial or other reimbursement matter.

Healthcare Provider Authorization Signature: _____ **Date:** _____

COVID-19 TEST MENU

PCR	☐ **CV19** – RT-PCR	☐ **SABR** – Xpert® Xpress Rapid PCR for SARS-CoV-2/Flu/RSV
	☐ **ACCL** – Accula™ Rapid PCR	☐ **CUEH** – Cue Rapid PCR
ANTIGEN	☐ **AG19** – QuickVue Rapid Antigen	☐ **ACON** – Flowflex Rapid Antigen
ANTIBODY	☐ **NPAB** – N Protein IgG/IgM Antibody	☐ **IGMG** – S Protein IgG/IgM Antibody
	☐ **CVAB** – Neutralizing Antibody	
OTHER	☐ **BIOF** – BioFire® Respiratory Panel	

Note: The SARS-CoV-2 Tests are neither approved nor cleared by the FDA. They are being provided under an FDA Emergency Use Authorization (EUA) and are compliant with 42 USC § 263 (CLIA).

SPECIMEN SOURCE

☐ **NS** – Anterior Nasal Swab (both nostrils)	☐ **NP** – Nasopharyngeal Swab	☐ **CS** – Cheek Swab
☐ **SA** – Saliva	☐ **S** – Serum	☐ **P** – Plasma

FOR LABORATORY USE ONLY

Accession #:	Patient ID:	
Client/Physician #:	Date Received: ____ / ____ / _____	Time: ___ : ___ ☐ AM ☐ PM