

**Virant Diagnostics, Inc.**

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**COVID-19 Test Requisition Form**

Place Barcode Label Here

Collection Date: \_\_\_ / \_\_\_ / \_\_\_  
 Collection Time: \_\_\_ : \_\_\_  AM  PM

**PATIENT INFORMATION**

Last Name:	First Name:	Date of Birth:
Email:	Phone:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	City: State:	Zip:

**DIAGNOSIS CODES**

<input type="checkbox"/> Z20.822: Contact with and (suspected) exposure to COVID-19	<input type="checkbox"/> Z03.818: Encounter or observation for suspected exposure to COVID-19	<input type="checkbox"/> Z11.52: Encounter for screening for COVID-19
<input type="checkbox"/> Z86.16: Personal history of COVID-19	<input type="checkbox"/> Z01.84: Encounter for antibody detection	<input type="checkbox"/> Z28.310: Unvaccinated
<input type="checkbox"/> Z28.311: Partially vaccinated for COVID-19	<input type="checkbox"/> J06.9: Acute respiratory infection	<input type="checkbox"/> J12.82: Other viral pneumonia
<input type="checkbox"/> J40: Bronchitis	<input type="checkbox"/> B97.21 SARS-associated virus as the cause of disease	<input type="checkbox"/> B34.2: Coronavirus infection
<input type="checkbox"/> R06.02: Shortness of breath	<input type="checkbox"/> R05: Cough	<input type="checkbox"/> R50.9: Fever
<input type="checkbox"/> R07.1: Chest pain on breathing	<input type="checkbox"/> R34.1: Disturbance in smell	<input type="checkbox"/> R09.3: Abnormal sputum

**PATIENT CONSENT/AUTHORIZATION**

- I hereby authorize the release of medical information related to this service for submission of personal 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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**INSURANCE AND PAYMENT INFORMATION**

Bill Insurance (Attach copy of insurance card, front and back)  Bill Client  Bill Patient (Cash/Check/Credit Card)  Other:

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:

**HEALTHCARE PROVIDER INFORMATION**

Provider Name:	NPI:
Organization:	Phone:
Address:	City: State: Zip:

Provider Authorization Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**TEST MENU****PCR/OTHER**

Specimen Type:  Nasal swab  Nasopharyngeal swab  Cheek swab  Saliva

<input type="checkbox"/> RT-PCR (CPT codes U0004, U0005)	<input type="checkbox"/> RT-PCR with RNase kit (CPT codes U0004, U0005)
<input type="checkbox"/> Rapid RT-PCR (CPT code 87635)	<input type="checkbox"/> Flowflex Rapid Antigen (no insurance billing)
<input type="checkbox"/> Sequencing for SARS-CoV-2 Variant Identification (CPT code 87913)	

**ANTIBODY**

Specimen Type:  Nasal swab  Serum  Plasma

<input type="checkbox"/> N Protein IgG/IgM (CPT code 86328 x2)	<input type="checkbox"/> N and S Protein IgG/IgM (CPT code 86328 x2)
<input type="checkbox"/> Neutralizing Antibody (CPT code 86409)	

**FOR LABORATORY USE ONLY**

Accession #:	Patient ID:
Client/Physician ID:	Date Received: ___ / ___ / ___ Time Received: ___ : ___ <input type="checkbox"/> AM <input type="checkbox"/> PM