Infectious Disease **Test Requisition**

FIRMALAB BIO-DIAGNOSTICS

PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) | SEX ASSIGNED AT BIRTH ◯ Male ◯ Female ◯ Unknown

ADDRESS

CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PHONE | EMAIL

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME | INSTITUTION PHONE

PROVIDER LAST NAME | PROVIDER FIRST NAME

NPI # | PROVIDER ADDRESS

CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PROVIDER PHONE/FAX/EMAIL | FAX REPORT TO

PATIENT ALLERGIES

☐ Penicillins ☐ Sulfonamides ☐ Tetracyclines ☐ Colistin
☐ Macrolides ☐ Cephalosporins ☐ Carbapanems ☐ Flouroquinolones

Other _____

Symptomatic as defined by CDC? ☐ YES ☐ NO ☐ UNKNOWN

RACE/ ETHNICITY

☐ AI - American Indian or American Native
☐ A - Asian
☐ B - Black or African American
☐ PI - Native Hawaiian or Pacific Islander
☐ H - Hispanic
☐ NH - Non-Hispanic
☐ W - White ☐ O - Other ☐ U - Unknown

Test Options

SAMPLE TYPE: ☐ Nasopharyngeal ☐ Oropharyngeal

COLLECTION DATE (MM/DD/YYYY)

☐ Mini RPP Panel (COVID-19, FluA/B, RSV)

Individual Targets:
- ☐ SARS-CoV-2 ONLY (COVID-19)
- ☐ Influenza A
- ☐ Influenza B
- ☐ RSV A/ B

ICD-10 CODES - Select/indicate ICD-10 code(s)

- ☐ Pneumonia (COVID-19)
  J12.89 Pneumonia, Other viral pneumonia
  B97.29 Pneumonia, Other coronavirus
- ☐ Lower Respiratory Infection (COVID-19)
  J22: Acute lower respiratory infection, Unspecified
  B97.29 Pneumonia, Other coronavirus
- ☐ Acute Bronchitis (COVID-19)
  J20.8 Acute Bronchitis, Unspecified
  B97.29 Pneumonia, Other coronavirus
- ☐ Bronchitis (COVID-19)
  J40 Bronchitis, Unspecified
  B97.29 Pneumonia, Other coronavirus
- ☐ Z03.818 Suspected exposure to COVID-19
- ☐ Z20.828 Known Exposure to COVID-19
- ☐ R05 Cough
- ☐ R06.02 Shortness of Breath
- ☐ R50.9 Fever, Unspecified
- ☐ J01.90 Acute Sinusitis, Unspecified
- ☐ J02.9 Acute Pharyngitis, Unspecified
- ☐ J06.9 Acute Upper Respiratory Infection, Unspecified
- ☐ J18.9 Pneumonia, Unspecified organism
- ☐ J20.9 Acute Bronchitis, Unspecified
- ☐ J32.9 Chronic Sinusitis, Unspecified
- ☐ Other:

BILLING INFORMATION

☐ **OPTION 1:** Insurance Billing

PRIMARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

SECONDARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

☐ **OPTION 2:** Institutional **OR** ☐ **OPTION 3:** Self Pay

INSTITUTION/PAYOR FIRST & LAST NAME NAME | ATTENTION TO

ADDRESS | CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PHONE | FAX | EMAIL

Patient Consent:
I am voluntarily seeking laboratory service and hereby consent to provide a sample as requested. I have the right to refuse testing, but I understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded to the laboratory immediately.

Patient Signature: _____ Date: _____

Physician Certification:
This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek further counsel. The patient has voluntarily decided to have the test performed by Firma Lab Diagnostics Lab. As the medical provider, I am responsible for documenting applicable ICD-10 diagnosis codes.

Provider Signature: _____ Date: _____

 | 870 Vine St. Los Angeles CA 90038 | info@firmalab.com | +1 (800) 810-3040 | **CLIA:** 05D0992853 | **Director:** Dr. Terence McGee, MD | **CAP:** 8042697