



Date Received Stamp

*PRACTICE INFORMATION

PLACE BARCODE HERE

Practice Name:

*Address:

*Physician:

*NPI:

*Phone No:

And on each tube lengthwise

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PLEASE ATTACH DETAILED MEDICAL RECORDS, INSURANCE CARD FRONT/BACK, AND CLINICAL INFORMATION TO THE REQUISITION FORM.

COVID AND FLU, RESPIRATORY PANEL REQUISITION FORM

PATIENT INFORMATION*

SPECIMEN COLLECTION INFORMATION

*First Name: *Address: *Collection Date: MM / DD / YYYY
Middle Name: *City: *State: *Collected By:
*Last Name: *Zip Code: *Time:
*Gender: Male Female Others *Date of Birth: MM / DD / YYYY *Mobile No:
Bill To: Insurance Medicare Medicaid Patient Client Bill
Oropharyngeal Swab Nasopharyngeal Swab
Saliva

INSURANCE BILLING (Include copy of both sides of insurance card)

Insurance Company: Policy# Group:

*ICD-10 Diagnosis Code(s):

Test Requested
RT-PCR Covid-19 Covid-19 and Influenza A+B RT-PCR
If RT-PCR Covid 19 Negative run the below selected test
Respiratory Pathogen Panel

Respiratory Pathogen Panel

- Virus
1. Human Parainfluenza virus 4
2. Human Respiratory Syncytial Virus A (RSVA)
3. Human herpesvirus 6
4. Human Bocavirus
5. Human Rhinovirus 1/2
6. Human Parainfluenza virus 1
7. Enterovirus pan
8. Human Coronavirus OC43
9. Human Coronavirus 229E
10. Human herpesvirus 4
11. Adenovirus 1/2
12. Human Parainfluenza virus 3
13. Influenza A/H3
14. Human herpesvirus 5
15. Human Coronavirus HKU1
16. Enterovirus D68
17. Human Rhinovirus 2/2
18. Human Coronavirus NL63
19. Influenza A Virus pan
20. Influenza A/H 1-2009
21. Human Parainfluenza virus 2
22. Human Metapneumovirus (hMPV)
23. Respiratory Syncytial Virus B
24. Influenza B Virus
25. Human Herpesvirus 3
26. Adenovirus 2/2
Bacteria
1. Chlamydia pneumoniae
2. Klebsiella pneumoniae
3. Acinetobacter baumannii
4. Streptococcus pyogenes
5. Pseudomonas aeruginosa
6. Moraxella catarrhalis
7. Legionella pneumophila
8. Haemophilus influenzae
9. Staphylococcus aureus
10. Enterobacter cloacae
11. Streptococcus pneumoniae
12. Mycoplasma pneumoniae
13. Enterobacter aerogenes
14. Bordetella bronchiseptica/parapertussis/pertussis
15. Bordetella pertussis
ABR
1. Methicillin 1 2. UreR 3. FemA

Symptoms:

Is the patient experiencing any of the following symptoms? Yes No Unknown
Date of symptom onset? MM / DD / YYYY
Fever or chills Sore Throat Headache Muscle or body aches Congestion or runny nose Nausea or vomiting
Cough Shortness of Breath Diarrhea Fatigue Loss of Smell and Taste

Is patient a resident of a congregate care setting? Yes No Unknown

First Test: Yes No Unknown
Employed in Healthcare: Yes No Unknown
Symptomatic as defined by CDC: Yes No Unknown
If Yes, Date of Symptom Onset (MM/DD/YY):
Hospitalized: Yes No Unknown
ICU: Yes No Unknown
Resident in a congregate care setting: Yes No Unknown
Pregnant: Yes No Unknown
Patient race: American Indian or Alaska Native
Asian Black or African American
Native Hawaiian or Other Patient Islander
White Other Unknown
Patient Ethnicity: Hispanic Non Hispanic Unknown

Respiratory Pathogen Panel Medical Necessity

Since indicated that you wish to order a Respiratory Pathogen Panel OR you have requested a Covid-19 PCR test and reflex to the Respiratory Pathogen Panel if Covid-19 is negative, please complete the Medical Necessity Letter below. Please do not use a stamped signature on this form.

Dear Claims Specialist:

Please consider this letter of Medical Necessity a formal request for full coverage of the Respiratory Pathogen Panel testing services that I intend to prescribe for your subscriber (Patient Name Listed Above. The results will assist me in making patient specific clinical decisions regarding the medical management of your subscriber.

To provide the safest, most effective, and affordable medical care possible, the requested molecular testing is medically necessary for my patient for the following reason(s):

- If patient has tested negative for Covid-19, as their health care provider I wish to reflex to RPP
Patient requires screening to Pathogen Exposure
Patient is experiencing respiratory symptoms and I would like to determine best treatment

Others:
Because of this, the Respiratory Pathogen Panel will help me to determine what viruses or bacteria illnesses to treat.

DISCLAIMER:
NO COVID-19 DIAGNOSTIC TESTING IS GUARANTEED TO BE 100% ACCURATE AT THIS TIME. MicroGen Health DISCLAIMS RESPONSIBILITY FOR FALSE OR INACCURATE TEST RESULTS, INCLUDING WITHOUT LIMITATION, ANY FALSE NEGATIVE RESULTS WHICH MAY RESULT FROM SITUATIONS THAT INCLUDE BUT ARE NOT LIMITED TO: (I) TESTING PERFORMED PRIOR TO THE INCUBATION PERIOD OF COVID-19, WITH SUCH INCUBATION PERIOD PRESENTLY UNDERSTOOD TO BE THREE TO FIVE AND TWO-TENTHS (3 - 5.2) DAYS FOLLOWING AN INDIVIDUAL'S EXPOSURE; (II) INABILITY TO OBTAIN A GOOD SPECIMEN SOURCE FOR REASONS THAT MAY INCLUDE, BUT ARE NOT LIMITED TO, AN INDIVIDUAL BEING ASYMPTOMATIC, AND/OR THE SPECIMEN COLLECTION NOT FOLLOWING MicroGen Health INSTRUCTIONS; (III) THE LACK OF SUFFICIENT PRESENCE OF COVID-19 IN THE SPECIMEN BECAUSE THE VIRUS PRESENT IN THE INDIVIDUAL IS IN THE INCUBATION PERIOD, MEANING THE TESTED PERSON IS NOT SHEDDING COVID-19 AT THE TIME OF SPECIMEN COLLECTION; AND/OR (IV) LABORATORY SENSITIVITY BEING UNABLE TO DETECT LOW VIRAL LOADS.

No test other than the specific Respiratory test ordered shall be performed on the biological sample and the sample shall be destroyed no more than fourteen days after the sample was taken, unless a longer period of retention is expressly authorized in a separate consent form.

I, the undersigned, understand I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization, I am acknowledging that payment(s) be made on my behalf to MicroGen Health for any services provided to me by MicroGen Health. I also allow the release of any medical information necessary to process claim.

*Patient Signature: *Date: MM / DD / YYYY
*Physician Signature: *Date: MM / DD / YYYY