Date Received Stamp

MicroGen HEALTH

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*PRACTICE INFORMATION		PLACE BARCODE HERE
Practice Name:		And on each tube lengthwise
*Address:		
*Physician:		
*NPI:	*Phone No:	

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*

*First Name:
Middle Name:
*Last Name:
*Gender: ○ Male ○ Female ○ Others
*Date of Birth: MM / DD / YYYY

*Address:
*City: *State:
*Zip Code:
*Mobile No:

Bill To: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient ☐ Client Bill

SPECIMEN COLLECTION INFORMATION

*Collection Date: MM / DD / YYYY
*Collected By:
*Time:
☐ 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. Chlamydophila 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 ☐ Cough ☐ Sore Throat ☐ Shortness of Breath ☐ Headache ☐ Diarrhea ☐ Muscle or body aches ☐ Fatigue ☐ Congestion or runny nose ☐ Loss of Smell and Taste ☐ Nausea or vomiting

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.

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

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