COVID-19 TEST REQUISITION FORM

BD-F-028v7 04-16-2021

Lab Use Only

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CLIA Number: 05D0643914 • NPI: 1396837605 • CA License: CLF4033 • Federal Tax ID: 94-3147701

PATIENT INFORMATION (Please Print)

Visit www.igenex.com for the most up-to-date billing and payment information.

Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip

Telephone	Email	Gender ❑ Female ❑ Male	Date of Birth *(MM-DD-YYYY)*

Race and Ethnicity

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Caucasian
- ❑ Pacific Islander or Native Hawaiian
- ❑ Race Unknown
- ❑ Other Race: ____________________
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Ethnicity Unknown

PREPAYMENT AND INSURANCE INFORMATION – Please select one of the following payment methods (REQUIRED)

❑ **YES, I have an active health insurance coverage**

Please submit an out-of-network claim to my health insurance carrier

- Please attach front and back of your health insurance cards
- Please complete and sign the attached COVID-19 Health Insurance Claim Submission Form

❑ **YES, I have an active Medicare – Medical (Part B) Coverage**

Medicare Number: ____________________

- Please attach front and back of your Medicare Card
- Please complete and sign the attached Medicare Patient Insurance Information Form

❑ **NO, I do not have an active health insurance coverage**

- Please provide us with your SSN or State of residence below. If SSN is not available, please enter State Identification or Driver's License

Social Security Number/State Identification/Driver's License	State of Residence

Prepayment is required for the following test(s) or panel ordered:

***C140, C300, C400, COV1, COV2, and *COV5T**

❑ **Check Number:** ____________________

❑ **Credit Card:** **Visa, MasterCard, Discover or American Express Only**

IGeneX does not accept Healthcare Financing Credit or CardCredit Cards

Credit Card Number:	
Card Holder's Name:	
Expiration Date (MM/YYYY):	Billing Zip Code:

By signing this document, I accept financial responsibility and am aware of the testing fees. I authorize IGeneX, Inc. to release information received including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives. I understand IGeneX, Inc. may be filing an out of network claim to my insurance company on my behalf. I further understand my health plan/insurance carrier may not approve and reimburse for testing in full due to coverage limits, benefits exclusions, lack of authorization, medical necessity or otherwise. My signature indicates I acknowledge and accept full financial responsibility for all services rendered at IGeneX, Inc. Reference Laboratory.

SIGN HERE: Required to process test(s)

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PATIENT or RESPONSIBLE PARTY'S SIGNATURE (REQUIRED)

REFERRING PHYSICIAN or LABORATORY INFORMATION

Client ID	Physician/Laboratory	Credentials	**Client Agreement on file (required)** ❑ **Referring Physician/Laboratory**

Primary Practice Address		
City	State	Zip
Telephone (for reporting positive results)	Fax Number (for reporting)	
Email	NPI (Required)	

DX Codes (Required): Please select or indicate all possible diagnosis codes.

Code	Description
❑ **U07.1**	2019-nCoV acute respiratory disease
❑ **Z03.818**	Encounter for observation for suspected exposure to other biological agents ruled out
❑ **Z20.828**	Contact with and (suspected) exposure to other viral communicable diseases
❑ **Z11.59**	Encounter for screening for other viral diseases
❑ **Other:** ____________ ; ____________ ; ____________	

Only tests that are medically reasonable and necessary for the diagnosis or treatment of a Medicare patient will be reimbursed. The Office of Inspector General takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil penalties under the False Claims Act.

SIGN HERE: Required to process test(s)

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REFERRING PHYSICIAN'S SIGNATURE (REQUIRED)

Please provide Specimen Information and mark Panel/Test(s) on page 2 ▶

*Test/Panels are not yet available for NY Residents

Patient Information (required)	
Name (*Last, First, Middle*)	**Date of Birth** (*MM-DD-YYYY*)

SPECIMEN INFORMATION

Reminder: Patient's Last Name, First Name, Collection Date and Date of Birth must be on tube labels.

Specimen Collected Performed By:	Contact Number:

Specimen Type/Source:	Collection Date &Time:	Storage:
❑ Nasopharyngeal swab (NP)	______ / ______ / ______ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Nasal swab (NS)	______ / ______ / ______ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Oropharyngeal swab (OP)	______ / ______ / ______ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Saliva (S)	______ / ______ / ______ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Serum (SST)	______ / ______ / ______ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Whole Blood (Heparin Tube)	______ / ______ / ______ ____ : ____ AM/PM	❑ Room Temp ONLY

Visit www.igenex.com for SPECIMEN COLLECTION & HANDLING INSTRUCTIONS FOR SARS-CoV-2 TESTING ▶

TEST MENU

Test Code	Test/Panel Description	Specimen Requirement	CPT Code	Prepay Price
❑ C100	SARS-CoV-2, RT PCR – NP	Nasopharyngeal swab	U0003, U0005	$135.00
❑ C120	SARS-CoV-2, RT PCR – NS	Nasal swab	U0003, U0005	$135.00
❑ C130	SARS-CoV-2, RT PCR – S	Saliva	U0003, U0005	$135.00
❑ *C140	SARS-CoV-2, IGXSpot	1 Full Heparin Tube Must be received within 48 hours of collection at RT	86352	$295.00
❑ C200	SARS-CoV-2, RT PCR – OP	Oropharyngeal swab	U0003, U0005	$135.00
❑ C300	SARS-CoV-2 ImmunoBlot IgM	0.5mL Serum	86769	$135.00
❑ C400	SARS-CoV-2 ImmunoBlot IgG	0.5mL Serum	86769	$135.00
❑ COV1	SARS-CoV-2 IMMUNOBLOT PANEL 1 Panel includes: SARS-CoV-2 ImmunoBlot IgM & IgG	0.5mL Serum	86769 x2	$250.00
❑ COV2	SARS-CoV-2 COMPLETE PANEL 2 Panel includes: SARS-CoV-2, RT PCR SARS-CoV-2 ImmunoBlot IgM & IgG	Nasopharyngeal swab/Saliva/ Nasal swab Oropharyngeal swab 0.5mL Serum	86769 x2 U0003, U0005	$325.00
❑ *COV5T	SARS-CoV-2 (Vaccine Response) PANEL 5 Panel includes: SARS-CoV-2 IGXSpot, SARS-CoV-2 ImmunoBlot IgM & IgG	0.5mL Serum 1 Full Heparin Tube Must be received within 48 hours of collection at RT	86769 x2 86352	$395.50

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Patient Information (required)	
Name (*Last, First, Middle*)	**Date of Birth** (*MM-DD-YYYY*)

HEALTH INSURANCE CLAIM SUBMISSION FORM FOR COVID-19 TESTS ONLY

Please note:

- IGeneX is not an in-network provider and do not accept insurance reimbursement except for all FDA EUA Covid-19 diagnostic test, SARS-CoV-2 RT PCR test(s)
- We will perform an out-of-network claim directly with your insurance company only on the following ordered test(s):
  - **Test# C100, C120, C130, and C200**
- You will need to prepay for the following services rendered at IGeneX at the time specimen is sent. We accept Visa, MasterCard, Discover, American Express, Personal Checks or Money Orders. We will perform a courtesy out-of-network claim directly with your insurance company:
  - **Test# *C140, C300, C400, COV1, COV2, and *COV5T**

  (If you would like us to submit your claim to your insurance on your behalf, please provide a copy of the front and back of your insurance card and complete the following required fields to properly file insurance claims)
- We cannot file claim(s) on behalf of the patient for services provided by your referring physician
- Be sure your referring physician has provided the appropriate diagnosis code(s) on test requisition form

Please provide a copy of the front and back of your insurance card(s) and complete the following required fields to properly file insurance claims:

PLEASE ATTACH A COPY OF YOUR MEDICARE OR INSURANCE CARD WITH THIS TEST REQUISITION FORM

PRIMARY INSURANCE INFORMATION				
Patient's Last Name		Patient's First Name		Middle Initial
Patient's Date of Birth MM / DD / YYYY	Gender ❑ Male ❑ Female	Relationship to Insured ❑ Child ❑ Spouse ❑ Self ❑ Other ______		
PRIMARY INSURANCE INFORMATION				
Primary Insurance Carrier ❑ HMO ❑ PPO		Policy ID Number	Group ID Number/ RxGrp	
Primary Insured's Last Name (if different from patient)		Primary Insured's First Name (if different from patient)		Middle Initial
Insured's Date of Birth MM / DD / YYYY	Insured's Gender ❑ Male ❑ Female	Primary Insurance Carrier's Telephone ( )		
Primary Insurance Claim Submission Address:		City	State	Zip Code

I authorize IGeneX to release information received including, without limitation, medical information, which includes laboratory test results, to my health plan/ insurance carrier and its authorized representatives. I understand IGeneX will be filing an out-of-network claim to my insurance company on my behalf. I further understand my health plan/ insurance carrier may not approve and reimburse for testing in full due to coverage limits, benefits exclusions, lack of authorization, medical necessity or otherwise. My signature indicates I acknowledge and accept full financial responsibility for all services rendered at IGeneX Reference Laboratory.

______________________ Insured's or Authorized Person's Signature

______________________ Print Name

______________________ Today's Date

NOTE: Your Healthcare information will be kept confidential, any information that we collect about you on this form will be kept in our office.

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