

## Client Information

Client Name

Client Code



COVID-19 REQUISITION

DATE COLLECTED

\_\_\_/\_\_\_/\_\_\_

TIME COLLECTED

\_\_:\_\_ (24/hr)

Mid Nare

Nasopharyngeal

Oropharyngeal

Saliva

## Patient Information

Last Name	First Name	MI	Gender	Date of Birth
Address	City	State	Zipcode	Race
Phone	SSN OR DL	Email		

## Physician Information

Name	Phone	NPI
Address	City	State
		Zipcode

Client Bill

Self Pay

Medicare

Medicaid

Tricare

Commercial

CARES Act

## Insurance Information

Insurance Name	Member ID	Group ID
----------------	-----------	----------

## Test To Be Performed

SARS-CoV-2 PCR & FLU AB

SARS-CoV-2 PCR

## Diagnosis Codes (ICD10) - Check All That Apply

- |  |  |
|--|--|
| <input type="checkbox"/> Z20.828 - Contact with and (suspected) exposure to other viral communicable diseases<br><input type="checkbox"/> R05 - Cough<br><input type="checkbox"/> R09.3 - Abnormal sputum<br><input type="checkbox"/> R07.9 - Chest, pain, unspecified<br><input type="checkbox"/> R07.2 - Precordial pain<br><input type="checkbox"/> R07.1 - Chest pain<br><input type="checkbox"/> R07.81 - Pleurodynia<br><input type="checkbox"/> R07.89 - Other chest pain<br><input type="checkbox"/> R07.82 - Intercostal pain<br><input type="checkbox"/> R09.89 - Other specific symptoms involving the circulatory & respiratory system<br><input type="checkbox"/> R53.82 - Chronic, fatigue, unspecified<br><input type="checkbox"/> R53.83 - Other fatigue<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ | <input type="checkbox"/> Z11.59 - Encounter for screening for other viral disease<br><input type="checkbox"/> R06.9 - Abnormalities of breathing, unspecified<br><input type="checkbox"/> R06.02 - Shortness of breath<br><input type="checkbox"/> R06.2 - Wheezing<br><input type="checkbox"/> R06.00 - Dyspnea, unspecified<br><input type="checkbox"/> R06.99 - Other form of dyspnea<br><input type="checkbox"/> R06.03 - Periodic breathing<br><input type="checkbox"/> R06.83 - Snoring<br><input type="checkbox"/> R06.89 - Other abnormalities of breathing<br><input type="checkbox"/> R06.1 - Stridor<br><input type="checkbox"/> R06.6 - Hiccough<br><input type="checkbox"/> R50.83 - Postvaccination fever<br><input type="checkbox"/> R50.9 - Fever, unspecified |
|--|--|

## Consent

I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own, and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen, is accurate. I further authorize Assure Laboratories, to release the results of this testing to the ordering facility and/or my insurance company. I authorize my insurance company to pay and mail directly to Assure Laboratories and its affiliated laboratories all benefits for payment of services rendered. I also authorize Assure Laboratories and its affiliated laboratories to endorse any checks received on my behalf for payment of services provided. I hereby irrevocably assign to Assure Laboratories and its affiliated laboratories all benefits under any policy of insurance indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action including legal suit, if for any reason my insurance company fails to make payment to benefits due. This assignment also includes all rights to recover attorney fees and costs for such action brought by the provider as my assignee.

Patient Signature	Date:
Physician Signature	Date:

## Assure Laboratories

assure-labs.com

Phone: 864-251-5466

Fax: 864-609-4045

CLIA: 42D2189536

William E. Roudebush, Ph.D., HCLD, ELD, CC(ABB)

1200 Woodruff Rd. STE H32, Greenville, SC 29607