



CLIA - 39D2175506

# Respiratory Panel (RPP) Test Requisition

(Orange Sections Required)

### Insurance ordering checklist

- ICD-10 Code(s)
- Clinician & Patient Signatures
- Copy of Patient Insurance Card

Order#:  Requisition#:  Client Acc#:  Client Req#:

Save Draft

Submit to Lab

## Patient Information

Last Name:  First Name:  Middle Name:  Patient DOB:  Date of Death (if applicable):  Date of Discharge (if applicable):  Patient Search

Street Address:  City:  State:  Country:  Zip:

Preferred Contact Phone Number:  Biological sex:  Gender Identity (if different from marked):  Race:

## Profile Information

Do you want to create profile?  Email Address\*:  Confirm Email\*:

## Sending facility

Facility Type:

Facility Name (Facility Code):  Address:

## Ordering physician and/or other licensed medical professional

Name:  Phone:  Fax:  Email:  NPI:

Please add electronic signature here:

Add Signature Clear

+ New

## Additional results recipients

Medical Professional Name (Clinician Code):

Primary Contact

Genetic Counselor Name (Clinician Code):

Primary Contact

**Billing Information**

**ACCEPTABLE PAYMENT METHODS: Insurance Billing, Clinic or Facility Billing, Patient Pay Billing (Self-Pay).**

Please select in the table below either the appropriate insurance provider, Clinic or Facility Billing, or Patient Pay Billing (Self-Pay).

<b>Patient Pay Billing</b>	<b>Clinic or Facility Billing</b>
The Lab will send an electronic invoice to the patient email listed above. The patient will be responsible for all charges related to this Test Requisition; Insurance will not be billed.	The Lab will send an invoice to the Clinic listed above. By selecting this option, the Clinic hereby accepts payment responsibility for all charges related to this Test Requisition.

**Insurance Billing: Please contact Patient Care for Eligibility**

Attach front and back of insurance card, clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays.

	Payer Code	Payer Name	Policy Number	GroupID	Relation To Insured	Active	
1						<input type="checkbox"/>	   

If you do not see your insurance provider in the list above, please choose Other and provide all insurance details in the box below:

- Please mark checkbox to confirm your payment method       If applicable please mark checkbox to confirm patients insurance card has been added as an attachment

**Billing ABN and Patient Protection Plan Information:**

A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing.

Billing laboratory preverifies insurance coverage and will contact the patient after the patient's sample is received if the out-of-pocket amount for testing is estimated to exceed \$100. Insurance pre-verification will not be performed for specific site analyses, unless specifically requested. All tests ordered with a bill type of insurance shall be processed and billed based on payor criteria.

**Indications for testing (check all that apply)**

ICD-10 Code(s):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> B99.9 Unspecified Infectious Disease               | <input type="checkbox"/> J00 Acute Nasopharyngitis               | <input type="checkbox"/> J01.90 Acute Sinusitis, Unspecified     |
| <input type="checkbox"/> J06.9 Acute Upper Respiratory, Unspecified         | <input type="checkbox"/> J22 Acute Lower Respiratory             | <input type="checkbox"/> J98.9 Respiratory Disorder, Unspecified |
| <input type="checkbox"/> J02.9 Sore throat                                  | <input type="checkbox"/> R05 Cough                               | <input type="checkbox"/> R50.9 Fever or chills                   |
| <input type="checkbox"/> R06.02 Shortness of breath or difficulty breathing | <input type="checkbox"/> R53.83 Fatigue                          | <input type="checkbox"/> R51 Headache                            |
| <input type="checkbox"/> R43.8 Loss of Smell or taste                       | <input type="checkbox"/> R43.0 Anosmia                           | <input type="checkbox"/> R09.81 Nasal congestion                 |
| <input type="checkbox"/> J34.89 Nose or nasal sinuses disorders             | <input type="checkbox"/> R11.2 Nausea with vomiting, unspecified | <input type="checkbox"/> R11.10 Vomiting                         |
| <input type="checkbox"/> R19.7 Diarrhea                                     | <input type="checkbox"/> Z20.828 Exposure                        | <input type="checkbox"/> Z11.59 Screening                        |
| <input type="checkbox"/> M79.10 Muscle or body aches                        | <input type="checkbox"/> R68.83 Chills without fever             |  |

Other ICD-10 Code(s):

**Specimen Information**

Nasalpharyngeal / Nasopharyngeal  Collected Date and Time:  Collected:  Collected By:

**Tests requested**

- Respiratory Gene Panel (RPP) Test  
 COVID Panel