QDxPathology SERVICES

COVID-19

R0000663395
CLIA ID# 31D2026917

PATIENT INFORMATION - ALL REQUIRED

Test will not be performed without ALL required patient information!

Date of Collection: _____ Time of Collection: _____
Last Name: _____ First Name: _____ MI: _____
Cell #: _____ Email: _____
Home #: _____ Street Address: _____
Apt: _____ City: _____ State: _____ Zip: _____
DOB: (MM/DD/YYYY): _____ / _____ / _____ SSN #: _____
(SSN # required for uninsured patients only)

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: _____

Race and Ethnicity - Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: _____

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

If the patient is traveling, please fill: Travel Date: _____ Airline: _____

REFERRING PHYSICIAN INFO. (Required)

INSURANCE INFO. (Required)

Policyholder Name: _____
Insurance Name: _____
Policy #: _____
Group #: _____

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

Please provide a copy of the front & back of insurance card(s).
For shipment of kits to patient, include credit card info. on back

SPECIMEN ID:

4182R-1 Rev N

LAB ACCESSION #:

EMPLOYER/SCHOOL/COLLEGE INFO. (Required)

☐ Not applicable Name: _____
Address: _____
Contact Number: _____ Occupation: _____

VACCINATION HISTORY

- ☐ Not Yet Vaccinated
- ☐ Fully Vaccinated

Vaccination completion date: _____
Brand of Vaccine: _____

CC REPORT

Date of Procedure: _____ Physician Performing Procedure: _____
Practice/Surgery Center: _____
Street Address: _____
City: _____ State: _____ Zip: _____

- ☐ Preoperative COVID-19 screening procedure

☐ SARS-CoV-2 (COVID-19) RT-PCR (Nasal swab)

- ☐ J20.8 Acute bronchitis due to other specified organisms
- ☐ J22 Unspecified acute lower respiratory infection
- ☐ J80 Acute respiratory distress syndrome
- ☐ R06.02 Shortness of breath
- ☐ R50.9 Fever unspecified
- ☐ J06.9 Acute upper respiratory infection, unspecified
- ☐ J98.8 Other specified respiratory disorders
- ☐ Z11.52 Encounter for screening for COVID-19
- ☐ Z20.822 Contact with and suspected exposure to COVID-19
- ☐ Z20.828 Contact with and suspected exposure to other viral communicable disease
- ☐ Z86.16 Personal history of COVID-19
- ☐ G2023 Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)
- ☐ J11.1 Flu like symptoms
- ☐ Z01.818 Encounter for other preprocedural examination, preprocedural examination NOS

- ☐ Z03.818** Possible exposure to COVID-19, ruled out
- ☐ Z11.59** Asymptomatic, no known exposure, results unknown or negative
- ☐ U07.1** COVID-19 virus identified
- ☐ J40** Bronchitis, not specified as acute or chronic
- ☐ J12.89** Other viral pneumonia

****For COVID-19, above codes must be billed in conjunction with the following code:**

- ☐ B97.29 Other coronavirus as the cause of diseases classified elsewhere

BOTH PATIENT AND PHYSICIAN MUST SIGN to approve testing

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: _____

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to QDx Pathology Services and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: _____

CMS requires physician signature on all requisitions. QDx Pathology Services is responsible for verifying signature prior to performing testing.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.qdxpath.com

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4182R-1 Rev N Patient Name/DOB: _____ Cell Number: _____ Collection Date: _____

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CREDIT CARD INFO.

☐ Mastercard ☐ Visa ☐ AmEx ☐ Discover ☐ Other: _____

Name on Card: _____

Card Number: _____ Exp. Date: (MM/YY): _____ / _____ CVV Code: _____

Amount: $_____ Signature: _____

ADVANCED BENEFICIARY NOTICE OF PAYMENT (ABN):

NOTE: This is to notify that your healthcare provider has good reason to think you this/the test(s).

Notifier:_____ Date: _____

Patient Name:_____

WHAT YOU NEED TO DO NOW:

▶ Read this notice so you can make an informed decision about your care.

▶ Ask us any questions that you may have after you finish reading.

☐ **I WANT THE TEST(S) ORDERED BY MY PHYSICIAN/PROVIDER**
QDx Pathology Services will bill your insurance.

▶ **Signing below means that you have received and understand this notice.**

Signature:_____ Date: _____