QDxPathology SERVICES

SPECIMEN ID:

RPP
Respiratory Pathogen Panels

R0000663394
CLIA ID# 31D2026917

PATIENT INFORMATION - ALL REQUIRED

Date of Collection: ____________________ Time of Collection: ______________________
Last Name: ___________________________ First Name: ________________ MI: ______
Cell #: ____________________________ Email: ______________________________
Street Address: ____
Apt: ________ City: _______________________________ State: _____ Zip: _________
DOB: (MM/DD/YYYY): ________ / _______ / _____________ SSN #: _________________
(SSN # required for self-pay patients only)

Gender Identity and Sexual Orientation

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

REFERRING PROVIDER INFO. (Required)

INSURANCE INFO. (Required)

Policyholder Name: ____
Insurance Name: ____

For patients using Medicare, please complete and sign the ABN form on the reverse side of this test requisition.

Group #: ___________________________________
Policy #: ___________________________________

Please provide a copy of the front & back of insurance card(s).

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

TESTS & PANELS

Stand-alone Tests :

- ☐ **SARS-CoV-2 -** nasal or nasopharyngeal swab
- ☐ **Group A Strep RT-PCR -** throat swab in Liquid Amies Medium

Panels: *(please select one only, see reverse side for panel offerings)*

- ☐ **RPP - Essential -** nasopharyngeal swab
- ☐ **RPP - Extended -** nasopharyngeal swab
  This panel must be requested with a D83.8, D83.9, and/or J12.89 ICD-10 code found below.

Common ICD-10 Codes (must be from the patient's medical record)

- ☐ J20.8 Acute bronchitis due to othe specified organisms
- ☐ J22 Unspecified acute lower respiratory infection
- ☐ J98.8 Other specified respiratory disorders
- ☐ R05.1 Acute Cough
- ☐ R05.2 Subacute Cough
- ☐ R05.3 Chronic Cough
- ☐ R06.2 Wheezing
- ☐ R06.02 Shortness of breath
- ☐ R07.0 Pain in throat
- ☐ R50.9 Fever unspecified
- ☐ R13.10 Dysphagia, unspecified
- ☐ R51.9 Headache, unspecified
- ☐ R53.81 Malaise and fatigue
- ☐ R68.83 Chills (without fever)
- ☐ Z20.822 Contact with and suspected exposure to COVID-19
- ☐ Other ____
- ☐ Z86.16 Personal history of COVID-19
- ☐ A37.90 Whooping Cough, unspecified species without pneumonia
- ☐ B95.0 Streptococcus, group A, as the cause of diseases classified elsewhere
- ☐ J04.0 Acute layngitis
- ☐ J06.9 Acute upper respiratory infection, unspecified
- ☐ J11.1 Flu like symptoms with other respiratory manifestations
- ☐ J02.9 Acute pharyngitis, unespecified
- ☐ J03.01 Acute recurrent streptococcal tonsillitis
- ☐ Z20.828 Contact with and suspected exposure to other viral communicable disease
- ☐ Z01.818 Encounter for other preprocedural examination, preprocedural examination NOS

One of the following codes MUST be selected if requesting RPP - Extended Panel

- ☐ D83.8** Other common variable immunodeficiencies
- ☐ D83.9** Common variable immunodeficiencies, unspecified
- ☐ J12.89** Other viral pneumonia

PROVIDER MUST SIGN TO APPROVE TESTING

Rev. U

Provider Signature: ____

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

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

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

PEEL LABEL HERE ▼ PEEL LABEL HERE ▼ PEEL LABEL HERE ▼ PEEL LABEL HERE ▼

R0000663394
Patient Name/DOB: ____________
Cell Number: ________________
Collection Date: ______________
4181R-1 Rev N

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4181R-1 Rev N

QDxPathology SERVICES

RPP - Essential

Includes:

- Influenza A Including:
  - Influenza A H1
  - Influenza A H1-2009pdm
  - Influenza A H3
- Influenza B
- Respiratory Syncytial Virus A/B (RSV)
- SARS-CoV-2

RPP - Extended

Includes:

Viruses

- Adenovirus
- Coronavirus (229E, HKU1, NL63, OC43)
- Human Metapneumovirus A/B
- Human Rhinovirus/ Enterovirus
- Parainfluenza (1, 2, 3, 4)
- Influenza A Including:
  - Influenza A H1
  - Influenza A H1-2009pdm
  - Influenza A H3
- Influenza B
- Respiratory Syncytial Virus A/B (RSV)

Bacteria

- Chlamydia pneumoniae
- Bordetella pertussis
- Mycoplasma pneumoniae

The below ABN form must only be submitted by patients using Medicare

A. QDx Pathology Services, 300 Columbus Circle, Suite A, Edison, NJ 08837, 1-866-845-6842

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. lab tests** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. lab tests** below.

D. Checked Lab Test(s) Only:	☐ RPP Essential: $99.84 ☐ RPP Extended: $265.41	☐ Sars-COV-2 RT-PCR $35.92 ☐ Group A Strep: $24.56 ☐ Other ___________________________
E. Reason Medicare May Not Pay:	Medicare does not pay for this test for your condition	
F. Estimated Cost		

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.
- Choose an option below about whether to receive the **D. lab tests** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D. lab tests** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. lab tests** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D. lab tests** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Patient please sign and complete

I. Signature:	**J. Date:**

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