Certivia Laboratories, LLC
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SARS COV-2 REQUISITION FORM (COVID 19)

Practice Information

1. PATIENT INFORMATION (病人信息)

Last Name（姓）________________

First Name（名）________________

MI ____________ DOB（出生年月）： / /

Sex（性别）：☐F（女） ☐M 男） ☐Unknown ☐ Other

Race（种族）：☐Asian （亚裔） ☐Black ☐White ☐Other, specify____________

☐ American Indian/Alaska Native ☐Native Hawaiian/Other Pacific Islander ☐Unknown

Resides （住址）： ☐Home（家庭） ☐Facility（公司）

Name of Facility（公司名称）： ☐N/A

Address（地址）：

City, State, ZIP（城市，州，邮编）：

Facility Contact Person（联系人）： Facility Contact Phone（联系电话）：

2. PAYMENT INFORMATION （付款信息）

BILL（账单）： ☐ Patient （**现金**） ☐ Insurance（保险）

☐**Expedited (加急:另付$50)** ☐**Sunday Reports (周日出报告:另付$30)**

☐ See attached copy of patient demographics/insurance info

Primary Insured Name（保险人姓名）：

Relationship to insured（与保险人关系）： ☐Self（本人） ☐Spouse （配偶） ☐Child （子女） ☐ Other

Insurance Company（保险公司）：

Member ID# Group ID#

City, State, ZIP:

☐No Fault, Workers Comp Claim #

Adjuster Name: Phone#

Date of Injury / / Body Part:

3. SPECIMEN COLLECTION

Date of Collection: Time: ☐AM ☐PM

Specimen submitted:

☐ Nasopharyngeal swab (NP) PREFERRED SPECIMEN TYPE ☐ Blood

☐ Nasopharyngeal/Oropharyngeal combined swabs (NP/OP)

☐ Oropharyngeal swab (OP)

4. SCREENINGS AND PANELS(检测方法)

COVID 19

☐ RT-PCR Real time polymerase chain reaction (RT-PCR) （核酸检测）

☐ IgG/IgM Rapid Test （抗体检测）

5. ICD-10 Codes

- ☐ Z03.818 possible exposure to COVID 19
- ☐ Z20.828 actual exposure COVID 19
- ☐ B99.9 Unspecified Infectious Disease
- ☐ J06.9 Acute Upper Respiratory, Unspecified
- ☐ J00 Acute Nasopharyngitis
- ☐ J22 Acute Lower Respiratory
- ☐ J01.90 Acute Sinusitis, Unspecified
- ☐ J98.9 Respiratory Disorder, Unsp Unspecified
- ☐ J02.9 Acute Pharyngitis, Unspecified
- ☐ R05 Cough
- ☐ R50.9 Fever, unspecified
- ☐ Z57.9 Occupational exposure to unspecified risk factor

6. RESULTS（结果送达方式）

RESULTS SENT TO: (SELECT ALL THAT APPLY)

☐Physicians Portal ☐ Fax ☐ **Email (电子邮箱地址)** ☐ Self-Pickup（自取）： Time and Date(自取日期时间)

7. PATIENT AUTHORIZATION（病人授权）

I authorize Certivia Laboratories, LLC to release the results of this testing to the treating authorized health care provider or facility. I hereby authorize my insurance benefits to be paid directly to Certivia Laboratories, LLC for services I received. I understand that Certivia may be an out-of-network provider with my insurer. I also understand that sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit to Certivia immediately. Failure to send payment with 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau. （**我授权 Certivia Laboratories 做此检测并承担相关费用。如果保险公司不承担，检测费用将由自己负责。不按期结清费用将承受相关法律责任。**）

Patient Signature（病人签名）： Date（日期）：

8. PHYSICIAN/ PATIENT SIGNATURE (签名)

I authorize the above ordered test(s) （我授权以上的检测）

Provider/Patient Signature（签名）：

Date（日期）：

BAR CODE/////////