COVID-19 TEST REQ FORM

Laboratory use only

9635 Hillcroft Street | Houston | Texas 77096 | 713-242-8653 |
CLIA Number: 45D2191047

www.rapiddxlaboratories.com

PATIENT INFORMATION

Last Name	First Name		Middle Initial
Mailing Address	City	State	Zip
Telephone	Email	Gender ❑ Female ❑ Male	Date of Birth *(MM-DD-YYYY)*

BILLING INFORMATION

❑ **YES, I have Medicare – Medical (Part B) Coverage**

Medicare Number: _____

- Please attach a copy of your Medicare Card
- Please complete and sign the attached Medicare Patient Insurance Information Form

❑ **NO, I do not have Medicare – Medical (Part B) Coverage**

If you do not have Medicare Coverage, you will be charged by your Referring Physician. Please do not submit any credit card or other billing information to RapidDx.

By signing this document, I accept financial responsibility and am aware of the testing fees. I understand I am responsible for submitting my own insurance claim. As a Medicare patient, I am also aware that I am responsible for payment to Rapid Dx LLC. if Medicare denies payment.

SIGN HERE: Required to process test(s)

_____

PATIENT or RESPONSIBLE PARTY'S SIGNATURE (REQUIRED)

REFERRING PHYSICIAN INFORMATION

Physician/Laboratory	Title	Client ID	❑ Bill to Referring Physician/Laboratory Client Agreement on file (required)
Primary Practice Address	City	State	Zip
Telephone (for reporting positive results)	Fax Number (for reporting)	NPI (Required)	
Email	DX Codes (Required): *Please provide all possible diagnosis codes if ordering for more than one disease.* _____ ; _____ ; _____ ; _____ ; _____		

Only tests that are medically reasonable and necessary for the diagnosis or treatment of a Medicare patient will be reimbursed. The Office of Inspector General takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil penalties under the False Claims Act.

SIGN HERE: Required to process test(s)

_____ _____ / _____ / _____

REFERRING PHYSICIAN'S SIGNATURE (REQUIRED) **TODAY'S DATE**

TEST ORDER

Code	Test/Panel Description	Specimen Requirement
❑COV	SARS-CoV-2	Nasopharyngeal swab
		Oropharyngeal swab
		1mL Serum

REFERRING LABORATORY INFORMATION

Referring Laboratory	Client ID	Billing Address		
Point of Contact	Contact Number	City	State	Zip
Email Address	Fax Number	NPI	Country	

SPECIMEN INFORMATION

Reminder: Patient's Last Name, First Name, Collection Date and Date of Birth must be on tube labels.

Specimen Collected By:	Contact Number:	PUI (if available, for reporting reference use only)

Specimen Type:	Collection Date &Time:	Storage:
❑ Nasopharyngeal Swab	_____ / _____ / _____ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Oropharyngeal Swab	_____ / _____ / _____ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer

See page 2 for SPECIMEN COLLECTION & HANDLING INSTRUCTIONS FOR SARS-CoV-2 TESTING ▶

RESULTS REPORTING

- Expected turn-around-time is 24 to 48 hours after receipt.
- Negative and positive result reports will be sent to Referring Physician's fax number on requisition.