INFECTIOUS DISEASE TEST REQUISITION

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CLIA # : 31D2157687

Collection Date: ________________ (Required)

Accession# : ________________

Dr's Office / Facility Name & Address:
(Required)

Fax results to:

Physician Name (Required)	Physician NPI # (Required)

Ordering Physician/Authorizing Medical Professional Signature: I hereby authorize testing for this patient. I have provided information regarding molecular testing and the patient has given consent for testing to be performed. I attest that the ICD-10 Diagnosis Codes provided are accurate records and supported by patient's record. I attest that these tests are medically necessary. I hereby authorize Q Answer lab, Inc to send these patient's test results to the patient's third party payer, if needed to appeal a denial of reimbursement prior to attempts to obtain reimbursement without the release of patient's results.

Ordering Physician / Authorizing Medical Professional Signature:
(Required)

Date: ________________ (Required)

Patient Information

Patient Last Name: (Required)	Patient First Name: (Required)	Patient DOB: (Required)	Gender:

Patient Consent Signature: I authorize the release of my medical information including test results for submission of personalized reports to my healthcare providers and insurance carrier(s). I request that payment of benefits be made to Q Answer lab, Inc on my behalf. If my policy does not allow for direct payment, I agree to relinquish allocated funds to Q Answer lab, Inc as compensation for services rendered. I also acknowledge that I will be liable for payments of deductibles, co payments and/ or co insurance as detailed by my healthcare insurer. I understand that I am liable for charges not covered by my healthcare insurer. I also authorize Q Answer lab, Inc to appeal insurance claims on my behalf. I acknowledge the benefits, risk and limitations of this testing as describe to me by a qualified healthcare provider. My insurance may not cover or pay full amount for Respiratory Pathogen Panel; I may be responsible for full or part of amount charged due to out of network benefits, deductible and co pays. Q Answer lab, Inc has my permission to bill my insurance carrier(s), this notice gives me the option to proceed with the procedure or decline. By signing this I have read all of the above and understand it. Medicare Advance Beneficiary Notice: Medicare will only pay for services that it determines to be reasonably and necessary under section 1882 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare Program standards, Medicare will deny payment for that service. Medicare usually does not pay for these tests for the reported diagnosis. By signing the Patient/Responsible Party Signature on this requisition, you are confirming your agreement to assume financial responsibility for the payment of these tests.

Patient Signature:
(Required)

Caregiver Name & Signature:

Date: ________________ (Required)

TEST PANEL

(From Nasopharyngeal Swab)

(Selection Required)

☐ **COVID-19** (SARS-CoV-2)**

** If a requisition includes both an order for COVID-19 and RPP, Q Answer Lab will conduct the ordered COVID-19 and will reflex to RPP if a negative COVID-19 result is obtained.

☐ **COVID-19 / Influenza A/B**
COVID-19 (SARS-CoV-2) and Influenza A/B single assay

☐ **COVID-19 / Flu A/B Panel w/ Reflex to RPP**
COVID-19 (SARS-CoV-2) and Influenza A / B single assay is performed. If negative results are obtained, then Q Answer Lab will proceed with Respiratory Pathogen Panel.

☐ **RPP** (Respiratory Pathogen Panel)**
Complete Respiratory Viral and Bacterial Panel*

Respiratory Pathogen Panel*

Virus

Influenza A, Influenza B, Influenza A H1N1, Influenza C, Parainfluenza 1, Parainfluenza 2, Parainfulenza 3, Parainfluenza 4, Rhinovirus, Adenovirus, Parechovirus, Enterovirus, Bocavirus, Respiratory Syncytial Virus A/B, Human metapneumovirus A/B, Coronavirus HKU1, Coronavirus OC43, Coronavirus NL63, Coronavirus 229E

Bacteria

Streptococcus pneumoniae, Chlamydia pneumoniae, Klebsiella pneumoniae, Mycoplasma pneumoniae, Staphylococcus aureus, Moraxella cattarhalis, Pneumocystis jirovecci, Haemophilus influenzae, Haemophilus influenzae type B, Legionella pneumophila/ longbeachae, Bordatella spp. (except Bordatella parapertussis)

ICD-10 Codes Please state why this test Constitutes medical necessity for the patient.
(Selection Required)

Code	Description	Code	Description
☐ J06.9	Acute upper respiratory infection, unspecified	☐ R53.83	Fatigue
☐ J11.1	Flu Like Symptoms	☐ R52	Body Ache generalized
☐ R50.9	Fever unspecified	☐ R09.81	Nasal Congestion
☐ R05.3	Cough Unexplained	☐ R06.02	Shortness of breath
☐ R43.8 / R43.9	Loss of taste / smell unspecified	☐ R51.9	Headache unspecified

Other