COVID-19
REQUISITION FORM

A2Z BioLabs
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PATIENT INFORMATION

Online Registration (Confirmation No)	Suffix	*First Name	Middle Initial	*Last Name
*Date of Birth (MM/DD/YYYY)	*Sex: ☐ Male ☐ Female ☐ Other			

*__Ethnicity:__ ☐ African American ☐ Asian ☐ Hispanic or Latino ☐ Not Specified

*__Race:__ ☐ American Indian / Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Unknown

*Address:	*City:	*State:	ZIP:
*Email:	*Phone Number:		

PROVIDER INFORMATION

Hospital, Laboratory or other Facility:		Address:	
Health Care Provider Name:		Primary Contact Name: (If not the Health Care Provider)	
Phone:	NPI#	Email:	Fax:

BILL TO

☐ Insurance ☐ Patient ☐ Provider or Business	**Insurance Name:**
Insurance ID:	**Insurance Group:**
DL / SSN:	

SPECIMEN INFORMATION

*__Reason for Submission__ ☐ Diagnostic ☐ Screening ☐ Contracted with COVID positive person ☐ Sickness ☐ Travel ☐ Possible Exposure to COVID positive person

Specimen Type: ☐ Sterile Container ☐ Blood Tube (Plasma, Serum or Whole Blood) ☐ Other (Specify)

Specimen Source: ☐ Nasopharyngeal (NP) ☐ Oral Saliva ☐ Other (Specify)

*__Test Request:__ ☐ SARS CoV-2 Molecular Test (RT-PCR) ☐ SARS CoV-2 Rapid Antigen ☐ SARS CoV-2 RT-PCR plus FLU (*Physican Referral Required) ☐ COVID-19 IgG / IgM Rapid Test

DIAGNOSIS CODES

☐ **Z03.818**------Possible exposure to COVID-19	☐ **R05**-------Other specified respiratory disorders
☐ **Z20.828**------Confirmed exposure to COVID-19	☐ **R50.9**-----Fever, unspecified
☐ **Z21.59**--------Screening for other viral diseases (asymptomatic)	☐ **R06.02**----Shortness of breath
☐ **Z21.52**--------Screening for COVID-19, asymptomatic	☐ **J20.8**------Acute bronchitis due to other specified organisms
☐ **Z20.822**------Contact with and (suspected) exposure to COVID-19	☐ **J98.8**------Cough
☐ **Z86.16**--------Personal history of COVID-19	☐ **J12.89**----Other viral pneumonia

PATIENT DECLARATION

☐ I agree that Laboratory will furnish to my designated insurance carrier the information on this form necessary for reimbursement. I hereby authorize service be performed and assign that benefits be payable to Laboratory. I understand that if any insurer doesn't pay and denies the claim as an uncovered service, I am responsible for payment. I authorize my insurance benefits to be paid directly to the laboratory for services I received. The laboratory is authorized to bill my insurance provider and to receive payment of benefits for the tests. I further authorize the testing laboratory and my physician to release to my insurance provider any medical information necessary to this claim.

*Patient Signature:	*Date of Collection (MM/DD/YY):	*Time of Collection: