



# RESPIRATORY PATHOGEN AT HOME TEST REQUISITION

## SPECIMEN COLLECTION INFORMATION

SELF  ASSISTED

Collector Name \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time: \_\_\_\_ : \_\_\_\_ am / pm

## ORDERING PROVIDER INFORMATION

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_ Genetic Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_  
 F  M

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PATIENT ID / EMR CODE: \_\_\_\_\_

## BILLING INFORMATION

## INSURED

COMMERCIAL  MEDICAID / MEDICARE  
 WORKERS COMP.  SELF  OTHER

Self  Spouse  
 Child  Other

Please attach patient insurance information and demographics.  
 I have attached medication list

## ADVANCED BENEFICIARY NOTICE

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. By signing the ABN below, you are confirming your agreement to assume financial responsibility.

## ICD - 10 Code(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CUSTOM PANELS

Comprehensive Respiratory Panel  
 COVID-19 + Flu + RSV  
 COVID-19 + Flu + RSV **reflex** COVID-19 Variant Analysis

## SAMPLE TYPE

NASO SWAB

## RESPIRATORY PANEL PCR

- coronaviruses NL63
- coronaviruses 229E
- coronaviruses OC43
- coronaviruses HKU1
- metapneumoviruses A/B
- rhinovirus
- respiratory syncytial viruses A
- respiratory syncytial viruses B
- adenovirus
- enterovirus
- parechovirus
- bocavirus

- Pneumocystis jirovecii
- Mycoplasma pneumoniae
- Chlamydophila pneumoniae
- Streptococcus pneumoniae
- Staphylococcus aureus
- Moraxella catarrhalis
- Bordetella spp.
- Klebsiella pneumoniae
- Legionella
- pneumophila/longbeachae
- Salmonella spp.
- Haemophilus Influenzae

- Influenza Panel
- Influenza A
- Influenza B
- Influenza C
- Parainfluenza Virus 1
- Parainfluenza Virus 2
- Parainfluenza Virus 3
- Parainfluenza Virus 4

## COVID-19 PCR

SARS-Corona Virus-2

**reflex** COVID-19 Genotype (96894-1)

COVID-19 variant analysis

## INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

PRIMAERY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

## CLIENT BILL

INSTITUTION/PRACTICE NAME

ATTENTION TO

ADDRESS

CITY STATE/PROVINCE POSTAL CODE COUNTRY

PHONE FAX/EMAIL

## SELF PAY

Use patient information above for billing

Use information below for billing

PAYOR LAST NAME

PAYOR FIRST NAME

ADDRESS

CITY STATE/PROVINCE POSTAL CODE COUNTRY

PHONE FAX/EMAIL

## PATIENT AUTHORIZATION

I certify that the specimen identified on this form is that of my own. I voluntarily donated the specimen for lab analysis in furtherance of my healthcare as needed by my healthcare provider and I have not adulterated it in any way to alter the test results. I, the patient, authorize AlphaDERA Labs, LLC to release my test results to my authorized healthcare provider. I hereby authorize my insurance benefits to be paid to AlphaDERA Labs, LLC directly, and acknowledge that I may be responsible for deductibles and/or co-pays for services that I have received, which have been requested by my healthcare provider.

I have read and agree to the Advanced Beneficiary Notice that I will be responsible for the cost of the ordered test (s) if Medicare denies payment.

Patient Signature

Date

Authorized Provider Signature:

Date