



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:	
<input type="checkbox"/> F <input type="checkbox"/> M					
Address:	City:	State:	Zip:		
PATIENT ID / EMR CODE:		PCP/Telehealth:	Live Transfer	Asynchronous	PCP

BILLING INFORMATION

INSURED

<input type="checkbox"/> COMMERCIAL	<input type="checkbox"/> MEDICAID / MEDICARE	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
<input type="checkbox"/> WORKERS COMP.	<input type="checkbox"/> SELF	<input type="checkbox"/> Child	<input type="checkbox"/> Other

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

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

SAMPLE TYPE

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

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