CLIA: 15D2096834 CLIA: 15D2093886

Medical Director: Dr. Poluru L. Reddy, Ph.D, DABCC, ASCP

COVID 19 Virus Nasal PCR Test and Rapid Strep A Antigen Test

Aria Diagnostics is an in-network Indianapolis based reference laboratory offering a test for respiratory pathogens including the novel corona virus associated with COVID-19.

Instructions for Patients:

Do not call the laboratory. A physician's order is required to perform this test.

1. Provide the attached order form to your health care provider along with an image of a government issued ID as well as the front and back of your insurance card. If you will not be using insurance benefits, please call 317-759-8530 for pricing information.
2. After the laboratory receives the completed order from your provider, Aria Diagnostics will call you to schedule a collection at one of our Indianapolis "drive up" collection sites.
3. Please bring a valid government issued ID and insurance card (if applicable) to the collection.
4. A nasopharyngeal swab will be used by a medical professional to obtain the sample to be tested.
5. The collection will take 30 seconds and will be performed while you sit in your car.
6. Test results will be delivered to your provider in 48–72 hours from collection.

Instructions for Providers:

1. Please fax (317-733-9451) or email (covidtest@ariadxs.com) completed Order Form. A cover sheet is not required. Please include a face sheet and associated medical notes, if applicable.
2. Upon receipt of the order, the laboratory will contact the patient to schedule a nasopharyngeal swab collection at one of our Indianapolis drive up collection sites following appropriate infection control precautions. +
3. Nucleic acid (DNA/RNA) will be extracted from the sample and the listed pathogens will be tested by real time PCR.
4. Results will be available electronically in 48–72 hours via an online portal. To recieve further instructions, please provide your email address on Order Form. If you would like results faxed, please include your fax number.
5. Please direct any questions to **covidtest@ariadxs.com**. Your email will receive a response and/or call back ASAP.

Resources:

Fact Sheet for Healthcare Providers issued by the CDC.
http://www.slh.wisc.edu/wp-content/uploads/2020/03/200204_FDA-fact-sheet-for-Healthcare-Providers_CDC-2019-nCoV-HCP.pdf

+"Specimens should be collected with appropriate infection control precautions following CDC Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings (2007)". Publication (updated in July 2019): https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

5635 West 96th Street | Suite 300 | Indianapolis, IN 46278
P: (317) 733-9454 | **F:** (317) 733-9451 | **E:** covidtest@ariadxs.com

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COVID 19 TEST LABORATORY ORDER FORM

5635 West 96th Street | Suite 300 | Indianapolis, IN 46278
P: (317) 733-9454 | F: (317) 733-9451 | E: covidtest@ariadxs.com

☐ **Nasopharyngeal Swab**

Date: ____ /____ /____ Time: _____ Initals: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

SSN: _____

Phone: _____

Date of Birth: ____ /____ /____ Sex: ☐ M ☐ F

Race:

☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaskan Native ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ Other

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Medications:

☐ No ☐ Yes _____

Include patient face sheet & insurance information.

Provider Information

Provider Name: _____

Facility Name: _____

Provider NPI: _____

Address: _____

City, State, Zip: _____

Phone: _____

☐ **Check to recieve faxed test results**

Fax #: _____

☐ **Check to recieve online test results and portal instructions**

Email: _____

Provider Test(s) Requested

☐ **COVID-19 (SARS-CoV-2 RNA) Test by RT-PCR**

Real time polymerase chain reaction (RT-PCR) performed on nucleic acid extracted from specimen collected using nasopharyngeal swab to qualitatively detect the following viral agent.

☐ **Rapid Strep A Antigen/COVID 19 PCR Combo Test**

Rapid chromatographic immunoassay for detection of strep A antigen and Real time polymerase chain reaction (RT-PCR) for the detection of the SARS-CoV-2 virus

ICD-10 Office Visit Code *(Minimum 2 required)*

☐ **Z03.818 possible exposure to COVID 19**
☐ **Z20.828 actual exposure COVID 19**
☐ **B99.9 Unsp Infectious Disease**
☐ **R05 Cough**
☐ **R50.9 Fever, unspecified**
☐ **Z57.9 Occupational exposure to unspecified risk factor**

☐ **Other** _____ _____

ORDERING PROVIDER AUTHORIZATION

I understand the purpose of this consent for use of my electronic signature and this has been explained to me. I hereby acknowledge and consent to my signature being used electronically on future laboratory orders by the above laboratories.

By their signature below, the ordering healthcare provider authorizes performance of the test(s) and indicates that he or she has explained the purpose of the test, the procedures, the benefits and the risks that are involved in testing to their patient and obtained the patient's informed consent in accordance with state and local laws.

MEDICAL NECESSITY: By submission of this requisition and accompanying specimen(s) to ARIAICL and/or its Affiliates, I authorized them to run all tests indicated on the requisition, certify that all tests are documented in the patient's medical records, meet the requirements of medical necessity (the OIG has cautioned that tests comprised of multiple procedure codes (molecular panels), may result in the ordering of tests which are not covered, reasonable or necessary). I understand if I knowingly cause a false claim to be submitted, I may be subject to legal sanctions and agree to provide ARIA/ICL all patient documentation upon request.

Provider Signature: _____

Date: ____ /____ /____

Fax or email completed form to:
317-733-9451, covidtest@ariadxs.com