GENOVA DIAGNOSTICS

Phlebotomy Code P C

Requisition

#602-318-5

Full Option

Note: This form must be completed (including responsible party signature) and returned with specimen in order to process this test.

GDX ID# **A95T4**

One Milo, Inc
Lawrence Leigh, MD
1010 Brickell Avenue
Suite 3303
Miami, FL 33131
305-707-8892
NPI: 1740228543

Date Final Sample Collected:
Mo. Day Year

Specimen Collection Type: (Check One)
❑ Nasopharyngeal (NP) ❑ Nasal Anterior
❑ Oropharyngeal (OP) ❑ Nasal Midtubinar
❑ Other:_____

CP 100

____ COVID-19 (SARS-CoV-2) #1015

Profile Components	CPT Codes
SARS-CoV-2 RNA (COVID-19), Qualitative NAAT	U0003

Federally Required Questions
(Practitioner to Complete):

1. Is this the patient's first COVID-19 (SARS-CoV-2) test?
❑ Yes ❑ No ❑ Unknown

2. Is the patient currently employed and working in healthcare?
❑ Yes ❑ No ❑ Unknown

3. Is the patient experiencing symptoms as defined by the CDC?
❑ Yes ❑ No ❑ Unknown
If Yes, please provide the date of symptom onset (mm/dd/yyyy)_____

4. Is the patient currently hospitalized due to COVID-19 (SARS-CoV-2)?
❑ Yes ❑ No ❑ Unknown

5. Is the patient currently in the ICU due to COVID-19 (SARS-CoV-2)?
❑ Yes ❑ No ❑ Unknown

6. Is the patient currently a resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting)?
❑ Yes ❑ No ❑ Unknown

7. Is the patient currently pregnant?
❑ Yes ❑ No ❑ Unknown

X _____

Physician's Signature & Date *(required)*

Please document medical necessity and the specific order for the test in the patient's medical record or progress notes with a signature and date from the referring physician in addition to providing a diagnosis code below.

Definition of Medical Necessity

All claims submitted to Medicare/Medicaid for Genova Diagnostics' laboratory services must be for tests that are medically necessary. "Medically necessary" is defined as a test or procedure that is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Consequently, tests performed for screening purposes will not be reimbursed by the Medicare program. Physicians may deem it medically necessary to order a single test or a portion of a profile.

Billing Options

Check only one option below. If no billing option selected, practitioner account may be billed.

❑ **Bill Practitioner Account** — *Complete on reverse:* 1
Not available in the states of NY, NJ, and RI

❑ **Bill Medicare or Tricare** — *Complete on reverse:* 1 2 4
Medicare Advantage Plans use the Bill Insurance option below.
All Medicaid plans use the No Insurance option

❑ **Bill Insurance with Patient Payment*** — *Complete on reverse:* 1 2 3 4
Initial Insurance Payment from Patient: $_____

❑ **No Insurance Billing - (Cash Pay)*** — *Complete on reverse:* 1 3 4
❑ *Pre-payment- please include full Cash Price amount* **Amount Enclosed: $**_____
❑ *Payment plan- please include 25% of the Cash Price amount** **Initial Installment: $**_____

For payments & pricing please visit https://www.gdx.net/pay or ask your healthcare practitioner.

Potential ICD-10 Codes and Conditions

IMPORTANT:
Please select or add the appropriate ICD-10 diagnosis code(s).

___ U07.1 COVID-19
___ Z20.828 Contact W And Exposure To Oth Viral Communicable Diseases
___ R05 Cough
___ R06.02 Shortness Of Breath
___ R50.9 Fever, Unspecified
___ R07.0 Pain In Throat
___ M79.1 Myalgia
___ R51 Headache
___ R43.0 Anosmia
___ R68.83 Chills (Without Fever)
___ R19.7 Diarrhea, Unspecified

Other Codes:_____

CPT & ICD-10 Codes
Due to the possibility of regulatory and/or methodology changes, CPT and ICD-10 codes are subject to change without prior notification.

Clinical Findings/Clinical Impressions:

THIS SPACE FOR LAB USE ONLY

6023185

Save time by completing this form at www.gdx.net/register

Enter your online confirmation code: _____

OR Refer to the billing options on the front and fill in the required sections below. *(Please use black or blue pen).*

1 Patient Information Section *Required for all patients.*

Full SSN required for insurance billing and online access to your test results.

Patient Date of Birth mm/dd/yyyy: ☐☐ - ☐☐ - ☐☐☐☐ **Sex:** M ☐ F ☐ **Social Security #:** ☐☐☐ - ☐☐ - ☐☐☐☐

Patient Name (last): (first): (middle):

Mailing Address:

City: **State:** **Zip:** -

Cell Phone: **County:** **Country:**

Alternate Phone:

Email:

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Multiracial ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Unknown

Responsible Party Name: *(Other legal guardian or if patient is a minor child)*

Name (last): (first): (middle):

If you reside in OH or NH, the following fields are required:

Occupation: _____ Employer Address: _____

Employer: _____ _____

2 Insurance Information Section

List your primary insurance information here. Include copies of all your health insurance cards to ensure accurate claim filing.

(Print clearly)

Insurance Company: _____

Please include front/back copy of all health insurance cards

Claims Address: _____

City/State/Zip: _____

Phone #: _____

Subscriber Name: _____

Subscriber ID #/Medicare #: _____

Group #: _____

Subscriber Date of Birth: (mm/dd/yyyy) _____

Relation to Patient: ❑ Self ❑ Spouse ❑ Other _____

Please note: We do not participate with Medicaid. All Medicaid patients should use the no insurance option.

3 Payment Section *For Bill Insurance / No Insurance.*

Visit www.gdx.net/pay for additional details and to make your payment online!

Bill Insurance Option

If choosing to have us bill your commercial insurance or Medicare Advantage plan, **you do not need to include a payment at this time.**

We will bill a claim to your insurance and you will receive a statement if there is an amount due.

Payment from: ❑ Practitioner ❑ Patient

Payment type: ❑ Payment online: *(Patient only)* **www.gdx.net/pay** 6-Digit Confirmation Code

❑ Check #_____ Amount: $_____

Make checks payable in US dollars to Genova Diagnostics

❑ Credit Card Authorized Amount: $ _____

(Print clearly)

Credit Card #:

Background color is for security purposes

Expiration Date: ____/____ CVV: _____

Cardholder Signature: _____

Printed Name: _____

Card Holder's Billing Zip Code: _____

For more payment information, visit our website: **www.gdx.net/pay**. Your practitioner will also have the payment information on their lab fee schedule.

No Insurance Option (Cash Pay)

If you are not using insurance, please complete the payment section to the right and provide the cash price for this test.

We will provide an insurance ready receipt upon completion of your test.

4 Patient/Responsible Party Acknowledgement *Please read and sign below.*

I have read the Billing Guidelines and I understand my responsibilities as described within them.

Except in the case of pre-payment I authorize the payment of all medical benefits to be paid directly to Genova Diagnostics and authorize the release of any medical information required for my health plan to process/pay claims resulting from my testing services. I understand that the tests listed on the front of this form may be out of network for my health plan and acknowledge my financial responsibility per my plan benefits and according to the applicable billing guidelines. If Genova Diagnostics participates with my health plan: 1) I acknowledge that payment will be applied toward the patient responsibility after my health plan has processed the claim, and 2) I understand that the tests on the front of this form may be deemed not medically necessary, experimental, or investigational by my health plan and authorize the services to be performed and to be financially responsible for the cash price described in the company's fee schedules.

Medicare Patients should refer to the Advanced Beneficiary Notice document in the collection pack (if applicable) related to medical necessity for certain tests.

I authorize Genova Diagnostics to act as my representative in any claim appeal process. I permit a copy of this requisition to be used in place of the original.

Under the General Data Protection Regulation (GDPR) issued by the European Commission, Genova Diagnostics is a third-party processor of that Customer Personal Data; the above signed Practitioner/Clinician is a controller and/or processor, as applicable, of that Customer Personal Data under the European Data Protection Legislation; and each party will comply with the obligations applicable to it under GDPR Legislation with respect to the processing of that Customer Personal Data. Genova Diagnostics is permitted to process Customer Personal Data only in accordance with applicable law: (a) to provide the services as designated above and related technical support; (b) as further specified via Customer's use of the Services; (c) as documented in the form of the applicable Agreement, including this Data Processing Amendment; and (d) as further documented in any other written instructions given by Customer and acknowledged by Genova Diagnostics as constituting instructions for purposes of this Data Processing Amendment. The customer should contact the provider of record for details regarding the scope of processing agreement and subject's personal data rights.

Patient/Responsible Party Name: _____ Date: _____

Signature (required): _____

QUESTIONS?
1-800-522-4762

5 Visit Your Patient Resource Center

• Access test results • Make payments • Complete health surveys

Log On At: **www.gdx.net/prc**

GENOVA DIAGNOSTICS | 63 Zillicoa Street Asheville, NC 28801 | 800.522.4762 www.GDX.net

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