COVID-19 TEST REQUISITION FORM

BD-F-028v10 01-08-2024

Lab Use Only

IGeneX Inc.
556 Gibraltar Drive | Milpitas | CA 95035 - 6315 | T: (800) 832-3200 | F: (408) 935-8272 | www.igenex.com
CLIA Number: 05D0643914 • NPI: 1396837605 • CA License: CLF4033 • Federal Tax ID: 94-3147701

PATIENT INFORMATION (Please Print)

Visit www.igenex.com for the most up-to-date billing and payment information.

Last Name	First Name		Middle Initial
Mailing Address	**City**	**State**	**Zip**
Telephone	**Email**	**Gender** ❑ Female ❑ Male	**Date of Birth** *(MM-DD-YYYY)*

Race and Ethnicity

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Caucasian
❑ Pacific Islander or Native Hawaiian
❑ Race Unknown
❑ Other Race: _____
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Ethnicity Unknown

PREPAYMENT AND INSURANCE INFORMATION – Please select one of the following payment methods (REQUIRED)

❑ **YES, I have an active health insurance coverage**

Please submit an out-of-network claim to my health insurance carrier

- Please attach front and back of your health insurance cards
- Please complete and sign the attached COVID-19 Health Insurance Claim Submission Form

❑ **YES, I have an active Medicare – Medical (Part B) Coverage**

Medicare Number: _____

- Please attach front and back of your Medicare Card
- Please complete and sign the attached Medicare Patient Insurance Information Form

❑ **Check Number:** _____

❑ **Credit Card:** Visa, MasterCard, Discover or American Express Only

IGeneX does not accept Healthcare Financing Credit or CardCredit Cards

Credit Card Number:

Card Holder's Name:

Expiration Date (MM/YYYY): **Billing Zip Code:**

By signing this document, I accept financial responsibility and am aware of the testing fees. I authorize IGeneX, Inc. to release information received including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives. I understand IGeneX, Inc. may be filing an out of network claim to my insurance company on my behalf. I further understand my health plan/insurance carrier may not approve and reimburse for testing in full due to coverage limits, benefits exclusions, lack of authorization, medical necessity or otherwise. My signature indicates I acknowledge and accept full financial responsibility for all services rendered at IGeneX, Inc. Reference Laboratory.

SIGN HERE: Required to process test(s)

_____

PATIENT or RESPONSIBLE PARTY'S SIGNATURE (REQUIRED)

REFERRING PHYSICIAN or LABORATORY INFORMATION

Client ID	Physician/Laboratory		Credentials	**Client Agreement on file (required)** ❑ Referring Physician/Laboratory
Primary Practice Address			**DX Codes (Required):** Please select or indicate all possible diagnosis codes.	
			❑ **U07.1**	2019-nCoV acute respiratory disease
City	**State**	**Zip**	❑ **Z03.818**	Encounter for observation for suspected exposure to other biological agents ruled out
Telephone (for reporting positive results)	**Fax Number** (for reporting)		❑ **Z20.828**	Contact with and (suspected) exposure to other viral communicable diseases
Email	**NPI (Required)**		❑ **Z11.59**	Encounter for screening for other viral diseases
			❑ **Other:** _____ ; _____ ; _____	

Only tests that are medically reasonable and necessary for the diagnosis or treatment of a Medicare patient will be reimbursed. The Office of Inspector General takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil penalties under the False Claims Act.

SIGN HERE: Required to process test(s)

_____

REFERRING PHYSICIAN'S SIGNATURE (REQUIRED)

Please provide Specimen Information and mark Panel/Test(s) on page 2 ▶

Patient Information (required)	
Name (*Last, First, Middle*)	**Date of Birth** (*MM-DD-YYYY*)

SPECIMEN INFORMATION

Reminder: Patient's Last Name, First Name, Collection Date and Date of Birth must be on tube labels.

Specimen Collected Performed By:	Contact Number:

Specimen Type/Source:	Collection Date &Time:	Storage:
❑ Nasopharyngeal swab (NP)	_____ / _____ / _____ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Nasal swab (NS)	_____ / _____ / _____ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Oropharyngeal swab (OP)	_____ / _____ / _____ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer
❑ Saliva (S)	_____ / _____ / _____ ____ : ____ AM/PM	❑ Room Temp ❑ Refrigerator ❑ Freezer

Visit www.igenex.com for SPECIMEN COLLECTION & HANDLING INSTRUCTIONS FOR SARS-CoV-2 TESTING ▶

TEST MENU

Test Code	Test/Panel Description	Specimen Requirement	CPT Code	Prepay Price
❑ C100	SARS-CoV-2, RT PCR – NP	Nasopharyngeal swab	87635	$135.00
❑ C120	SARS-CoV-2, RT PCR – NS	Nasal swab	87635	$135.00
❑ C130	SARS-CoV-2, RT PCR – S	Saliva	87635	$135.00
❑ C200	SARS-CoV-2, RT PCR – OP	Oropharyngeal swab	87635	$135.00
❑ CF500	SARS-CoV-2 + Flu A/B + RSV, RT-PCR - NP	Nasopharyngeal swab	87637	$185.00
❑ CF600	SARS-CoV-2 + Flu A/B + RSV, RT-PCR - NS	Nasal swab	87637	$185.00
❑ CF700	SARS-CoV-2 + Flu A/B + RSV, RT-PCR - OP	Oropharyngeal swab	87637	$185.00
❑ CF800	SARS-CoV-2 + Flu A/B + RSV, RT-PCR - S	Saliva	87637	$185.00

This Bottom Portion
Intentionally Left Blank

Patient Information (required)

Name (*Last, First, Middle*)	Date of Birth (*MM-DD-YYYY*)

HEALTH INSURANCE CLAIM SUBMISSION FORM FOR COVID-19 TESTS ONLY

Please note:

- IGeneX is not an in-network provider and does not accept insurance reimbursement except for all FDA EUA Covid-19 diagnostic test, SARS-CoV-2 RT PCR test(s), influenza A virus, and/or influenza B virus, and respiratory syncytial virus.
- We will perform an out-of-network claim directly with your insurance company only on the following ordered test(s):
  - **Test# C100, C120, C130, C200, CF500, CF600, CF700, and CF800**
- We cannot file claim(s) on behalf of the patient for services provided by your referring physician
- Be sure your referring physician has provided the appropriate diagnosis code(s) on test requisition form

Please provide a copy of the front and back of your insurance card(s) and complete the following required fields to properly file insurance claims:

PLEASE ATTACH A COPY OF YOUR MEDICARE OR INSURANCE CARD WITH THIS TEST REQUISITION FORM

PRIMARY INSURANCE INFORMATION

Patient's Last Name	Patient's First Name	Middle Initial

Patient's Date of Birth	Gender	Relationship to Insured
MM / DD / YYYY	❑ Male ❑ Female	❑ Child ❑ Spouse ❑ Self ❑ Other _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier ❑ HMO ❑ PPO	Policy ID Number	Group ID Number/ RxGrp

Primary Insured's Last Name (if different from patient)	Primary Insured's First Name (if different from patient)	Middle Initial

Insured's Date of Birth	Insured's Gender	Primary Insurance Carrier's Telephone
MM / DD / YYYY	❑ Male ❑ Female	( )

Primary Insurance Claim Submission Address:	City	State	Zip Code

I authorize IGeneX to release information received including, without limitation, medical information, which includes laboratory test results, to my health plan/ insurance carrier and its authorized representatives. I understand IGeneX will be filing an out-of-network claim to my insurance company on my behalf. I further understand my health plan/ insurance carrier may not approve and reimburse for testing in full due to coverage limits, benefits exclusions, lack of authorization, medical necessity or otherwise. My signature indicates I acknowledge and accept full financial responsibility for all services rendered at IGeneX Reference Laboratory.

_____	_____	_____
Insured's or Authorized Person's Signature	Print Name	Today's Date

NOTE: Your Healthcare information will be kept confidential, any information that we collect about you on this form will be kept in our office.