

### PATIENT INFORMATION (REQUIRED)

Date of Collection: \_\_\_\_\_ Time of Collection: \_\_\_\_\_  
 Cell #: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 DOB (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN #: \_\_\_\_\_  
*(SSN # required for uninsured patients only)*

#### Gender Identity and Sexual Orientation

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Male                   | <input type="checkbox"/> Transgender Male       | <input type="checkbox"/> Straight or Heterosexual   |
| <input type="checkbox"/> Female                 | <input type="checkbox"/> Transgender Female     | <input type="checkbox"/> Lesbian, Gay or Homosexual |
| <input type="checkbox"/> Non-Binary/Genderqueer | <input type="checkbox"/> Choose not to disclose | <input type="checkbox"/> Bisexual                   |
|   |   | <input type="checkbox"/> Other: _____               |

#### Race and Ethnicity — Select all that apply

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> American Indian or Alaska Native          | <input type="checkbox"/> Asian                  | <input type="checkbox"/> Hispanic or Latino     |
| <input type="checkbox"/> Black or African American                 | <input type="checkbox"/> White                  | <input type="checkbox"/> Non-Hispanic or Latino |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Choose not to disclose | <input type="checkbox"/> Other: _____           |

*Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)*

### REFERRING PHYSICIAN INFORMATION (REQUIRED)

### INSURANCE INFORMATION (REQUIRED)

Policyholder Name: \_\_\_\_\_  
 Insurance Name: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group #: \_\_\_\_\_

Bill Insurance  
 Bill Client  
 Self Pay

Please provide a copy of the front & back of insurance card(s).

SPECIMEN ID:



LAB ACCESSION #: \_\_\_\_\_

### TESTS & PANELS

#### Stand-alone Tests :

- SARS-CoV-2 - nasal or nasopharyngeal swab
- Group A Strep RT-PCR - throat swab in Liquid Amies Medium

#### Panels: (please select one only, see reverse side for panel offerings)

- RPP - Essential** - nasopharyngeal swab
- RPP - Extended** - nasopharyngeal swab  
*This panel must be requested with a D83.8, D83.9, and/or J12.89 ICD-10 code found below.*

#### Common ICD-10 Codes (must be from the patient's medical record)

- |  |   |
|--|---|
| <input type="checkbox"/> J20.8 Acute bronchitis due to other specified organisms | <input type="checkbox"/> Z86.16 Personal history of COVID-19  |
| <input type="checkbox"/> J22 Unspecified acute lower respiratory infection       | <input type="checkbox"/> A37.90 Whooping Cough, unspecified species without pneumonia                         |
| <input type="checkbox"/> J98.8 Other specified respiratory disorders             | <input type="checkbox"/> B95.0 Streptococcus, group A, as the cause of diseases classified elsewhere          |
| <input type="checkbox"/> R05.1 Acute Cough                                       | <input type="checkbox"/> J04.0 Acute laryngitis   |
| <input type="checkbox"/> R05.2 Subacute Cough                                    | <input type="checkbox"/> J06.9 Acute upper respiratory infection, unspecified                                 |
| <input type="checkbox"/> R05.3 Chronic Cough                                     | <input type="checkbox"/> J11.1 Flu like symptoms with other respiratory manifestations                        |
| <input type="checkbox"/> R06.2 Wheezing  | <input type="checkbox"/> J02.9 Acute pharyngitis, unspecified   |
| <input type="checkbox"/> R06.02 Shortness of breath                              | <input type="checkbox"/> J03.01 Acute recurrent streptococcal tonsillitis                                     |
| <input type="checkbox"/> R07.0 Pain in throat                                    | <input type="checkbox"/> Z20.828 Contact with and suspected exposure to other viral communicable disease      |
| <input type="checkbox"/> R50.9 Fever unspecified                                 | <input type="checkbox"/> Z01.818 Encounter for other preprocedural examination, preprocedural examination NOS |
| <input type="checkbox"/> R13.10 Dysphagia, unspecified                           |   |
| <input type="checkbox"/> R51.9 Headache, unspecified                             |   |
| <input type="checkbox"/> R53.81 Malaise and fatigue                              |   |
| <input type="checkbox"/> R68.83 Chills (without fever)                           |   |
| <input type="checkbox"/> Z20.822 Contact with and suspected exposure to COVID-19 |   |
| <input type="checkbox"/> Other _____   |   |
- One of the following codes MUST be selected if requesting RPP - Extended Panel**
- D83.8\*\*** Other common variable immunodeficiencies
  - D83.9\*\*** Common variable immunodeficiencies, unspecified
  - J12.89\*\*** Other viral pneumonia

### PROVIDER MUST SIGN TO APPROVE TESTING

Provider Signature: \_\_\_\_\_

CMS requires provider signature on all requisitions.  
 LabGenomics is responsible for verifying signature prior to performing testing.

Patient Signature: \_\_\_\_\_

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to LabGenomics and/or lab services provider.  
 I assume responsibility for payment of charges not covered by my healthcare insurer.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.labgusa.com

PEEL LABEL HERE ▼

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Patient Name/DOB: \_\_\_\_\_  
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**RPP - Essential**

Includes:

- Influenza A Including:  
Influenza A H1  
Influenza A H1-2009pdm  
Influenza A H3
- Influenza B
- Respiratory Syncytial Virus A/B (RSV)
- SARS-CoV-2

**RPP - Extended**

Includes:

**Viruses**

- Adenovirus
- Coronavirus (229E, HKU1, NL63, OC43)
- Human Metapneumovirus A/B
- Human Rhinovirus/ Enterovirus
- Parainfluenza (1, 2, 3, 4)

- Influenza A Including:  
Influenza A H1  
Influenza A H1-2009pdm  
Influenza A H3
- Influenza B
- Respiratory Syncytial Virus A/B (RSV)

**Bacteria**

- Chlamydia pneumoniae
- Bordetella pertussis
- Mycoplasma pneumoniae

**The below ABN form must only be submitted by patients using Medicare**
**A.** LabGenomics, 300 Columbus Circle, Suite A, Edison, NJ 08837, 1 (866) 845-6842

**B.** Patient Name:

**C.** Identification Number:

**Advance Beneficiary Notice of Non-coverage (ABN)**

**NOTE:** If Medicare doesn't pay for **D. lab tests** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. lab tests** below.

<b>D. Checked Lab Test(s) Only:</b>	<input type="checkbox"/> RPP Essential:.....\$99.84 <input type="checkbox"/> RPP Extended:.....\$265.41	<input type="checkbox"/> Sars-COV-2 RT-PCR.....\$35.92 <input type="checkbox"/> Group A Strep:.....\$24.56 <input type="checkbox"/> Other _____
<b>F. Reason Medicare May Not Pay:</b>	Medicare does not pay for this test for your condition	
<b>F. Estimated Cost</b>		

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. lab tests** listed above.

**Note:** If you choose Option 1 or 2, we may help to use other insurance you might have, but Medicare cannot require us to do this.

<b>G. OPTIONS: (Check only one box. We cannot choose a box for you.)</b>
<input type="checkbox"/> <b>OPTION 1:</b> I want the <b>D. lab tests</b> listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> <b>OPTION 2:</b> I want the <b>D. lab tests</b> listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/> <b>OPTION 3:</b> I don't want the <b>D. lab tests</b> listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

*Patient please sign and complete*



<b>I. Signature:</b> _____	<b>J. Date:</b> _____
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