

# PHARYNGITIS/LARYNGITIS TEST REQUISITION FORM

## Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Gender: Male \_\_\_ Female \_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

## ORDERING CLINICIAN / LABORATORY INFORMATION

Facility/Practice Name: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

NPI #: \_\_\_\_\_

**Physician Signature:**

X \_\_\_\_\_

*My Signature, as attending physician, serves as authorization of this test as medically necessary.*

## Billing Information

**(please include a copy of the front & back of the insurance card)**

**BILL:**

Medicare \_\_\_ Medi-Cal \_\_\_ Insurance \_\_\_

Policy Name Holder (if not patient)

\_\_\_\_\_

Patient relationship to policy holder

Self: \_\_\_ Spouse: \_\_\_ Child: \_\_\_ Other: \_\_\_\_\_

Policy holder Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Social Security # \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Insurance ID: \_\_\_\_\_

Employer/Company Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Authorization (Patient Signature):

X \_\_\_\_\_

**ABN:** I request and authorize KPC Biotech Molecular Laboratory to perform the designated test(s) on the DNA sample provided by me. My signature above constitutes my acknowledgement that I have been informed of the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional. I also understand that reference/testing lab reserves the right to provide de-identified information of a statistical nature to accrediting agencies and reserves the right to use such anonymous information.

**Assignment of Benefits:** I hereby authorize the entity to bill my insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with it's collection. I hereby authorize the entity, or their designee, to appeal my health plan on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

## ICD-10 CODES

SPECIMEN TYPES: Oropharynx Swab

COMMON SIGNS & SYMPTOMS: Consider if patient presents with pain in throat, fever, pharyngeal edema, patchy tonsillar exudates, or tender/swollen anterior cervical lymph nodes. J00, J02.9, J06.0, R05.1, R05.2, R50.9

ICD-10 Codes: \_\_\_\_\_

### Pharyngitis/Laryngitis

#### Bacteria

Streptococcus pyogenes (Group A Strep)

#### Atypical Bacteria

Mycoplasma pneumoniae

#### Viruses

COVID-19 Coronavirus (SARS-CoV-2)

Enterovirus

Rhinovirus (types A & B)

## Specimen Information

Collection Date: \_\_\_ / \_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

Source: Oropharynx Swab

Collector Initial: \_\_\_\_\_