

RESPIRATORY PLUS

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: Nasopharyngeal/Nares Swab
 COMMON SIGNS & SYMPTOMS: Consider if patient presents with symptoms of an upper respiratory tract infection, including cough, moderate temperature elevation, and mucopurulent sputum. J00, J02.9, J06.0, J06.9, J10.1, J18.9, J20.8, J22, R05.1, R05.2, R06.02, R06.2, R07.1, R50.9
 ICD-10 Codes: _____

Respiratory Plus

Bacteria

- Acinetobacter baumannii
- Enterobacter cloacae
- Haemophilus influenzae
- Klebsiella aerogenes
- Klebsiella pneumoniae
- Moraxella catarrhalis
- Proteus mirabilis
- Pseudomonas aeruginosa
- Staphylococcus aureus
- Staphylococcus epidermidis
- Streptococcus pneumoniae
- Streptococcus pyogenes (Group A Strep)

Atypical Bacteria

- Bordetella pertussis
- Chlamydia pneumoniae
- Legionella pneumophila
- Mycoplasma pneumoniae

Antibiotic Resistance Genes

- mecA

Viruses

- Adenovirus
- Bocavirus
- COVID-19 Coronavirus (SARS-CoV-2)
- Enterovirus
- Epstein-Barr Virus (mononucleosis)
- Human metapneumovirus (A)
- Human metapneumovirus (B)
- Influenza A
- Influenza B
- Other Coronaviruses (229E)
- Other Coronaviruses (HKU1)
- Other Coronaviruses (NL63)
- Other Coronaviruses (OC43)
- Parainfluenza virus (type 1)
- Parainfluenza virus (type 2)
- Parainfluenza virus (type 3)
- Parainfluenza virus (type 4)
- Respiratory Syncytial Virus (Types A & B)
- Rhinovirus (types A & B)

Specimen Information

Collection Date: ___ / ___ / ____ Time: _____
 Source: Nasopharyngeal/Nares Swab
 Collector Initial: _____