KarmaCare Dx™
A Division of KPC Biotech, Inc.

KPC Biotech Molecular Laboratory
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TREATABLE RESPIRATORY TEST REQUISITION FORM

Patient Information

Patient Name: _____

Date of Birth: ___ / ___ / _____ (MM/DD/YYYY)

Gender: Male __ Female __

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

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.

Specimen Information

Collection Date: ___ / ___ / _____ Time: _____

Source: Nasopharyngeal Swab

Collector Initial: _____

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.

ICD-10 CODES

SPECIMEN TYPES: Nasopharyngeal Swab
COMMON SIGNS & SYMPTOMS: Consider if patient presents with an acute upper respiratory tract Infection, high-grade fever, acute cough, runny nose, pain in throat, wheezing, nasal congestion, shortness of breath, or malaise. 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: _____

☐ Treatable Respiratory Viruses

- ☐ **Virus**
  - ☐ COVID-19 Coronavirus (SARS-CoV-2)
  - ☐ Influenza A
  - ☐ Influenza B
  - ☐ Respiratory Syncytial Virus (Types A & B)