Spectrum Health Regional Laboratories – SARS-CoV-2 (COVID-19) Test Requisition

Spectrum Health

Submitter Information (Office Info)	Patient Information
ID: Name: Address: Phone: Fax: Provider Name: _____ PRINT First and Last Name. No Initials. Required Provider Signature: _____	Name Last First MI Date of Birth Phone Sex Address City St Zip County

Billing Information (Choose One)

☐ **Bill this office/submitter (client bill)**

Inpatient, Skilled Nursing Facility (SNF), Nursing Facility (NF), Long Term Care (LTC), Employee Health

Client/Submitter Account Information:

☐ This office has a Spectrum Health Lab Account

ID:

Name:

☐ This office does NOT have a Spectrum Health Lab account

Billing contact name:

Billing contact phone:

Billing address:

☐ **Bill Patient/Patient Insurance***

Outpatient, Assisted Living (AL), Independent Living (IL), In-Home Hospice

Insurance Name:

Policy Number:

REQUIRED: Include a copy of the face sheet and insurance card.

***Note:** Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. Be certain the patient has signed the Advanced Beneficiary Notice (ABN) CMS-R 131 as needed.

Ordering Information

Order date:	**Diagnosis Code(s):**
Date of collection (REQUIRED):	**Collection Time (REQUIRED):**

Test Requested

☐ **Covid-19 PCR (LAB1230607, CPT U0002)**

- ☐ **Nasopharyngeal (NP) swab**
- ☐ **Nares (Nasal) swab**

☐ **Covid-19 IgG Antibody (LAB123023, CPT 86769)**

- ☐ **Blood, Venous** 5.0 mL Gold Top (SST)

Transport/Storage: Refrigerated

Ensure specimen container cap is secured.

REQUIRED QUESTIONS:

Is this test for ☐Diagnosis of ill patient OR ☐Screening

Symptomatic for COVID 19 as defined by CDC? ☐Yes OR ☐No If yes, please check which symptoms:

☐ Chills ☐ Diarrhea ☐ Fever ☐ Difficulty Breathing ☐ Loss of smell ☐ Muscle Pain ☐ Nausea Vomiting

☐ Sore Throat ☐ Cough ☐ Fatigue ☐ Loss of taste ☐ Nasal Congestion ☐ Runny Nose ☐ Severe Headache ☐ Shortness of Breath

Date of Symptom Onset: _____ **Hospitalized for COVID-19?** ☐Yes OR ☐No **Admitted to ICU for COVID 19?** ☐Yes OR ☐No

Employed in healthcare setting? ☐Yes OR ☐No **First COVID-19 Test?** ☐Yes OR ☐No

Pregnant? ☐Yes OR ☐No

Resident in congregate care/living setting? ☐Yes OR ☐No If yes, Residence Type:

☐ Boarding House ☐ Hospice ☐ Hospital ☐ Hospital Ship ☐ Hostel ☐ Nursing Home ☐ Secure Hospital ☐ Orphanage

☐ Long term care ☐ Military Housing ☐ Penal Institution ☐ Prison based care site ☐ Religious institutional housing ☐ Retirement home ☐ Substance abuse center ☐ Work ☐ Shelter Housing

-ALL INFORMATION REQUIRE FOR VALID ORDER-