GENESYS Diagnostics INC.

Respiratory Pathogen Panel

Requisition Form

*Information required for testing

Patient Information

LAST NAME* | FIRST NAME* | MI | DOB* (MM/DD/YYYY) | SEX | GENDER

ADDRESS | CITY | STATE | ZIPCODE | PHONE NUMBER | EMAIL ADDRESS

Billing Information (Please include a copy of insurance card(s) for billing purposes.)

*☐ CLIENT BILL ☐ INSURANCE ☐ SELF PAY ☐ MEDICARE/MEDICAID (☐ PRIMARY ☐ SECONDARY) RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURANCE NAME | MEMBER/POLICY ID | GROUP #

POLICY HOLDER NAME | POLICY HOLDER DOB (MM/DD/YYYY) | TEST INDICATION/ICD-10 CODE(S)*

Account Information

FACILITY/PRACTICE NAME* | PHONE NUMBER | FAX NUMBER | ORDERING PHYSICIAN NAME*

Specimen Information: Nasopharyngeal Swab

COLLECTION DATE: MM/DD/YYYY COLLECTION TIME: 00:00 AM/PM

Test(s) Requested*

☐ **Respiratory Pathogen Panel *(Including COVID)***

Includes:

Viral Targets
- Adenovirus
- Coronavirus 229E, HKU1, NL63, OC43
- Human Metapneumovirus
- Human Rhinovirus/Enterovirus
- Influenza A: A/H1, A/H3, A/H1-2009
- Influenza B
- Parainfluenza virus 1,2,3,4
- Respiratory syncytial virus (RSV)
- SARS-CoV-2 (COVID-19)

Bacterial Targets
- Bordatella parapertussis
- Bordatella pertussis
- Chlamydophila pneumoniae
- Mycoplasma pneumoniae

☐ **COVID *Only* Panel**
- SARS-CoV-2 (COVID-19)

ICD-10 Code(s)*	
☐ J11.0	Suspected influenza
☐ J12.89	Other viral pneumonia
☐ Z20.828	Contact with (suspected) exposure to other viral communicable diseases
☐ B97.29	Other coronavirus as the cause of diseases classified elsewhere
☐ Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out
☐ Z26.822	Contact with (suspected) exposure to COVID-19

Patient Authorization and Consent

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Genesys's Patient Informed Consent. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed.

Patient/Guardian Signature:* Date:*

☐ I do not consent to having my deidentified DNA sample used for internal research purposes.

Healthcare Provider Authorization

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed.

Healthcare Provider Signature:* Date:*

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines and must include diagnosis, symptoms and reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment a 'signed' Advanced Beneficiary Notice must be included.

234 Bank St. New London, CT 06320 Phone: (860) 574-9172 Fax: (860) 574-9264 info@gdilabs.com www.gdilabs.com CT-ST License # CL-0687