Location Name: _____

SITE: #_____

SPECIMEN INFORMATION: Date & Time Collected _____ Collected By _____

SPECIMEN TYPE: ☐ Nasopharyngeal Swab ☐ Throat Swab ☐ Nasal Swab ☐ Serum ☐ Other: _____

GRAVITY DIAGNOSTICS™

632 Russell St. ~ Covington, KY 41011
PH: 855-841-7111 CLIA# 18D1100471
Lab Director: Marc J Rumpler, PhD, DABCC

PATIENT INFO

Last Name First Name: ☐M ☐F

Address:

City/State/Zip

D.O.B. MM/DD/YYYY Phone:

PAYMENT INFO

Bill:

☐ **Medicare Part B** - By providing Medicare Part B payment information, I certify that I, the patient, or the patient in my care is not being covered by Medicare Part A, in-patient consolidated billing. **Initial**_____

☐ **Medicare Part A** - Direct Bill Facility for Consolidated Billing

☐ **Patient Insurance** ☐ **Patient Prepayment** (CC Auth Form or Check)

☐ **State Bill** (COVID-19 ONLY) ☐ **Facility/Practice** - Direct Bill Contract

For Patient Insurance (A legible copy of patient's insurance card(s) front & back is required.)

Carrier:

Policy #:

Group #:

Ship Sample, demographic information, copy of insurance card(s), copy of driver's license (if available) and this requisition form.

Per the CMS MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels L37713 LCD, tests that include more than 5 viral pathogens are non-covered

TESTING OPTIONS

Upper Respiratory Testing

Viral Targets

- ☐ Human Rhinovirus
- ☐ Influenza A
- ☐ Influenza B
- ☐ Parainfluenza Virus 1, 2, 3, 4
- ☐ Respiratory Synctial Virus A/B

Bacterial Targets

- ☐ Streptococcus pyogenes
- ☐ Mycoplasma pneumoniae
- ☐ Chlamydia pneumoniae
- ☐ Haemophilus influenzae B
- ☐ Klebsiella pneumoniae
- ☐ Moraxella catarrhalis
- ☐ Streptococcus pneumoniae
- ☐ Legionella pnuemophila/ longbeach
- ☐ Staphylococcus aureus
  - ☐ Reflex MRSA
- ☐ Salmonella Spp
- ☐ Bordetella Spp
- ☐ Haemophilus influenzae

Fungal Targets

- ☐ Pneumocystis Jirovecii (F)

Additional Viral Targets

- ☐ Adenovirus
- ☐ Human Enterovirus
- ☐ Human Metapneumovirus A/B
- ☐ Coronavirus HKU1
- ☐ Coronavirus NL63
- ☐ Coronavirus 229E
- ☐ Coronavirus OC43
- ☐ Influenza C
- ☐ Bocavirus
- ☐ Parechovirus

CORONAVIRUS (COVID-19)

- ☐ **SARS-CoV-2 RT-PCR** - Performed w/ Swab
- ☐ **SARS-CoV-2 IgM antibodies** - Performed w/ Serum
- ☐ **SARS-CoV-2 IgG antibodies** - Performed w/ Serum

COVID-19 ICD-10 Codes

- ☐ R05 Cough
- ☐ R50.9 Fever unspecified
- ☐ R06.02 Shortness of breath
- ☐ R43.9 Unspecified disturbances of smell and taste
- ☐ R07.0 Pain in throat
- ☐ R68.83 Chills (without fever)
- ☐ M79.1 Myalgia, unspecified site (muscle pain)
- ☐ U07.1 COVID-19, virus identified
- ☐ Z09 Encounter for follow-up exam after completed treatment
- ☐ Z86.19 Personal history of other infectious diseases
- ☐ Z01.84 Encounter for antibody response
- ☐ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- ☐ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out
- ☐ Other:_____

The COVID-19 Claims Reimbursement for Testing of the Uninsured Program

For claims for COVID-19 Testing and Testing-Related Items and Services, a patient is considered uninsured if the patient does not have coverage through an individual, or employer-sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program at the time the services were rendered.

I certify this statement to be true. If not eligible for uninsured coverage, I agree to provide updated and accurate insurance information.
Initial _____

Required Information:

1. State of Residency _____
2. SS#_____

If Social Security # is not available, provide:

1. State of Residency _____
2. Driver's License # or State Identification # _____

COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115

The following data elements must be collected and reported for SARS-CoV-2 laboratory tests, for the transmission of complete laboratory testing data to the CDC or the Secretary's designee. (Note: additional data elements may be requested at a future date.)

1. First test? ☐ Yes ☐ No ☐ Unknown
2. Employed in healthcare? ☐ Yes ☐ No ☐ Unknown
3. Symptomatic as defined by CDC? ☐ Yes ☐ No ☐ Unknown
4. if yes, then Date of Symptom Onset MM/DD/YYYY
5. Hospitalized? ☐ Yes ☐ No ☐ Unknown
6. If yes, ICU? ☐ Yes ☐ No ☐ Unknown
7. Resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting): ☐ Yes ☐ No ☐ Unknown
8. Pregnant? ☐ Yes ☐ No ☐ Unknown
9. Patient Race? (Circle) American Indian Asian African American Hawaiian White Unknown
10. Patient Ethnicity? (Circle) Hispanic/Latino Non-Hispanic/Latino Unknown
11. Patient Residence County or Territory? _____

UPPER RESPIRATORY ICD-10 Codes

Attention: Federal regulators require that only tests that are medically necessary for diagnosis and treatment of a patient's condition be ordered. ICD-10 code(s) is required to prove medical necessity for the test, and for insurance billing. Please include ONLY codes relating to the tests ordered. ***The below ICD-10 codes are frequently used and are in compliance with CGS LCD. Choose all that apply. If you do not see the appropriate code, please fill in the provided blank spaces***

UPPER RESPIRATORY

- ☐ J12.89 Other viral pneumonia
- ☐ J15.8 Pneumonia due to other specified bacteria
- ☐ J18.8 Other pneumonia, unspecified organism
- ☐ J18.9 Pneumonia, unspecified organism
- ☐ J20.8 Acute bronchitis due to other specified organisms
- ☐ J22 Unspecified acute lower respiratory infection
- ☐ J90 Pleural effusion, not elsewhere classified
- ☐ R05 Cough
- ☐ R06.00 Dyspnea, unspecified
- ☐ R06.02 Shortness of breath
- ☐ R06.2 Wheezing
- ☐ R07.0 Pain in throat
- ☐ R07.1 Chest pain on breathing
- ☐ R50.9 Fever, unspecified
- ☐ R53.81 Other malaise
- ☐ R53.83 Other fatigue
- ☐ U07.1 COVID-19, virus identified
- ☐ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- ☐ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out

OTHER

- ☐ _____
- ☐ _____

PATIENT CONSENT and ASSIGNMENT OF BENEFITS:

I request and authorize the CLIA accredited laboratory to perform the above designated test(s) on the sample provided by me. I understand Gravity Diagnostics may use my specimen and any testing performed on my specimen for research, development, and potential publication purposes so long as the information has been properly de-identified pursuant to law. Assignment of Benefits: I hereby assign all rights and benefits under my health plan and direct payments be made to Gravity Diagnostics, LLC for laboratory services furnished to me by Gravity Diagnostics, which I understand may be a non-participating provider with my health plan. I understand I am responsible for any amount not covered by insurance.

Patient Signature: _____

PROVIDER SIGNATURE and MEDICAL NECESSITY STATEMENT

My signature authorizes the providing laboratory and/or any of its affiliated corporations, owners and or doctors to perform and or reference out to another reference laboratory entity the above check-marked test(s) for the ICD-10 condition(s) identified. I certify based upon this patient's history, symptoms, examination findings and medical record that all ordered tests are medically necessary and understand that Medicare & Medicaid do not cover non-medically necessary screenings. I understand any component of any test may be ordered individually and only tests ordered will be reported on. In following the Centers for Disease Control and Prevention: Core Elements of Outpatient Antibiotic Stewardship guidelines, I am selecting Gravity Diagnostics for my infectious disease testing. Their next day turn-around time of results for their syndromic testing allows our facility to follow the CDC's recommendations of 1) only prescribing antibiotics when needed, and 2) minimizing misdiagnoses or delayed diagnoses leading to underutilization of antibiotics.

Provider Signature: _____ Date:_____

PRACTICE NAME: _____

PROVIDER NAME AND NPI# ☐ _____ _____

PROVIDER NAME AND NPI# ☐ _____ _____

PROVIDER NAME AND NPI# ☐ _____ _____

PROVIDER NAME AND NPI# ☐ _____ _____

PROVIDER NAME AND NPI# ☐ _____ _____

PROVIDER NAME AND NPI# ☐ _____ _____

PROVIDER NAME AND NPI# ☐ _____ _____