COVID-19 MOLECULAR TESTING

progenity®

PATIENT INFO

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY) PATIENT ID

TELEPHONE NUMBER

EMAIL

SEX ☐ Female ☐ Male ☐ Other/Unknown

RACE ☐ African American/Black ☐ Asian ☐ Native American ☐ White ☐ Other/Unknown

ETHNICITY ☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown

STREET NUMBER STREET NAME APT NUMBER

CITY STATE ZIP

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I may be responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim. By providing my telephone number or email address, I request that the laboratory release my test results and/or information about my testing directly to me via telephone or email.

☐ I authorize the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.

☐ I do not authorize the laboratory to retain and use my de-identified specimen and test data as described above.

REQUIRED PATIENT SIGNATURE X DATE (MM/DD/YY)

CLINICIAN INFO

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. By providing the patient's telephone number or email address, I authorize the laboratory to release test results directly to the patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

REQUIRED ORDERING CLINICIAN SIGNATURE X DATE (MM/DD/YY)

BILLING INFO

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

INSURANCE COMPANY

IPA NAME

MEMBER ID

☐ **UNINSURED** Seek federal funding (i.e. CARES Act). Ordering provider has verified uninsured status.

☐ **BILL PATIENT** Patient will be contacted to provide payment method.

☐ **CLIENT BILL**

TEST & SPECIMEN INFORMATION

☐ 3094 **SARS-CoV-2 RNA PCR Test**

Specimen Type:

- ☐ Nasal Swab
- ☐ Nasopharyngeal Swab
- ☐ Oropharyngeal Swab
- ☐ Other _____

Specimen Collection Date (MM/DD/YY)

Specimen Collection Time ☐ AM ☐ PM

MOLECULAR TEST SAMPLE COLLECTION & HANDLING GUIDELINES

For specifics on sample collection and handling guidelines, please visit our website at www.progenity.com/COVID19

- Preferred collection: Use flocked swabs.
- Other swabs are acceptable. EXCEPTIONS: Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit testing.
- Place swab immediately into transport media.

CLINICAL INFO

REQUIRED - **All clinical questions are mandatory for reporting.**

First test?	☐ Yes	☐ No	☐ Unknown
Employed in healthcare?	☐ Yes	☐ No	☐ Unknown
Symptomatic as defined by CDC?	☐ Yes	☐ No	☐ Unknown

If yes, date of symptom onset (mm/dd/yy)

Hospitalized?	☐ Yes	☐ No	☐ Unknown
ICU?	☐ Yes	☐ No	☐ Unknown
Resident in a congregate care setting?	☐ Yes	☐ No	☐ Unknown
Pregnant?	☐ Yes	☐ No	☐ Unknown

DIAGNOSTIC INFORMATION (ICD-10-CM)

REQUIRED - **Check all that may be applicable**[1, 2]

- ☐ Z20.822 Contact with and (suspected) exposure to COVID-19
- ☐ U07.1 COVID-19
- ☐ R05 Cough
- ☐ R06.02 Shortness of breath
- ☐ R50.9 Fever, unspecified
- ☐ J98.8 Other specified respiratory disorders
- ☐ J40 Bronchitis, not specified as acute or chronic
- ☐ J22 Unspecified acute lower respiratory infection
- ☐ J20.8 Acute bronchitis due to other specified organisms
- ☐ J12.82 Pneumonia due to coronavirus disease 2019
- ☐ J80 Acute respiratory distress syndrome
- ☐ B94.8 Sequelae of other specified infectious and parasitic diseases
- ☐ J96.0- Acute respiratory failure
- ☐ M35.81 Multisystem inflammatory syndrome
- ☐ M35.89 Other specified systemic involvement of connective tissue
- ☐ O98.5- Other viral diseases complicating pregnancy, childbirth and the puerperium
- ☐ Z11.52 Encounter for screening for COVID-19
- ☐ Z86.16 Personal history of COVID-19

☐ Other (please specify): _____

Testing not available in New York State.

COVID-19 PG-COV-1067-EN-v2

[1] *CMS and NCHS. ICD-10-CM Official Guidelines for Coding and Reporting. FY 2021 (October 1, 2020-September 20,2021). Accessed January 27, 2021. https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf*

[2] *CDC. New ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19). Effective: January 1, 2021. Accessed January 27, 2021. https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-19-508.pdf*

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