COVID-19 MOLECULAR TESTING

progenity®

PATIENT INFO

LAST NAME

FIRST NAME

PATIENT ID

DATE OF BIRTH (MM/DD/YYYY) | TELEPHONE NUMBER

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.

☐ 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. 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)

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]

☐	B97.29	Other coronavirus as the cause of diseases classified elsewhere
☐	J12.89	Other viral pneumonia
☐	J20.8	Acute bronchitis due to other specified organisms
☐	J22	Unspecified, acute lower respiratory infection
☐	J40	Bronchitis, not specified as acute or chronic
☐	J80	Acute respiratory distress syndrome
☐	J86.19	Personal history of other infectious and parasitic diseases
☐	J96.0	Acute respiratory failure
☐	J98.8	Other specified respiratory disorders
☐	O98.5	Other viral diseases complicating pregnancy, childbirth and the puerperium
☐	P35.8	Other congenital viral diseases
☐	R05	Cough
☐	R06.02	Shortness of breath
☐	R50.9	Fever, unspecified
☐	U07.1	COVID-19
☐	Z01.84	Encounter for antibody response examination
☐	Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
☐	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
☐	Z38	Liveborn infants according to place of birth and type of delivery
☐	Other (please specify):	

Testing not available in New York State.

[1] *CDC. ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Accessed Sept 24, 2020. https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf*

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