Coppe LABORATORIES

For Lab Use Only
Accnt#:
Mailer:
Date and Time Received:
Rec'd Condition:

COVID-19 TEST REQUEST FORM

ORDERING PHYSICIAN INFORMATION:

Name: _____ NPI #: _____

Clinic Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Reporting:

Contact Name : _____

Lab Results Email Address: _____

Reporting Fax: _____

TEST ORDERED: #6000 Coronavirus 2019-nCoV RT-PCR CPT87635; **$269**

STATEMENT OF MEDICAL NECESSITY: This requisition constitutes an order for services. I certify the services are medically indicated and necessary and they will assist me in treating my patients.

Physician Signature: _____

PATIENT INFORMATION:

Name (Last, First): _____ Date of Birth: _____ /_____ /_____ ☐ M ☐ F

Address: _____ Email: _____

City, State, Zip: _____ Phone: _____

PATIENT PROFILE:

Specimen Information: Date and time collected: _____ / _____ / _____ Time _____ AM/PM

Specimen Type:

☐ Nasal Swab/Saliva ☐ NP (nasopharyngeal)

Symptoms: Date started: _____ / _____ / _____

☐ Fatigue ☐ GI/Diarrhea ☐ Fever ☐ Cough ☐ Difficulty Breathing ☐ Non-Specific

Diagnosis Codes: _____ _____ _____

PAYMENT INFORMATION: (Must be completed)

Coppe Laboratories is a Fee-For-Service Provider. **Payment must be made in full at the time of sample submission.** We accept MasterCard, VISA, Discover, American Express or a check may be attached to the order.

Credit Card Number:_____-_____-_____-_____

Exp. Date:_____ CVV:_____ Name on Credit Card:_____

INSURANCE FILING:

Patients are responsible for filing claims with their insurance carrier. A paid receipt with diagnosis codes and CPT codes will be provided. Coppe Laboratories is not a Medicare provider.