Coppe LABORATORIES

COVID-19 TEST REQUEST FORM

For Hospital/Account Invoiced Billing Only

For Lab Use Only

Accnt#:
Mailer:
Date and Time Received:
Rec'd Condition:

ORDERING PHYSICIAN INFORMATION:

Physician Name:_____ NPI #: _____
Institution: _____
Phone:_____

Reporting:

Reporting Contact Name : _____
Lab Results Email Address: _____
Reporting Fax: _____

TEST ORDERED: #6000 Coronavirus 2019-nCoV RT-PCR CPT87635

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

Alternate Patient ID: _____

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: _____ _____ _____

BILLING INFORMATION:

Bill to: _____
City, State, Zip: _____
Contact Phone: _____

Address: _____
Billing Contact Name: _____
Contact Email: _____