

Certivia Laboratories
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Practice Information:

INFECTIOUS DISEASES REQUISITION FORM

PATIENT INFORMATION

Last Name	First Name	MI
DOB	Sex	Race
Street Address	City/State	ZIP Code
County	Phone Number	Email

Billing Information: Self Pay Insurance Client Bill
 Insurance Company: _____ Primary Insured Name: _____ Relationship to Insured _____
 Member ID#: _____ Group ID#: _____ City, State, ZIP: _____

I authorize Certivia Laboratories, LLC to release the results of this testing to the treating authorized health care provider or facility. I hereby authorize my insurance benefits to be paid directly to Certivia Laboratories, LLC for services I received. I understand that Certivia may be an out-of-network provider with my insurer. I also understand that sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit to Certivia immediately. Failure to send payment with 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

Patient Signature: _____ Date: _____

SPECIMEN INFORMATION

Collection Date: _____	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Specimen Submitted <input type="checkbox"/> Nasopharyngeal Swab (NP) <input type="checkbox"/> Nasopharyngeal/Oropharyngeal Combined Swab (NP/OP) <input type="checkbox"/> Oropharyngeal Swab (OP)
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SCREENINGS/PANELS	ICD10 CODES
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<input type="checkbox"/> COVID 19 <input type="checkbox"/> RT-PCR Real time polymerase chain reaction <input type="checkbox"/> RTP-PCR with reflex RPP <input type="checkbox"/> IgG/IgM Rapid Test <input type="checkbox"/> RESPIRATORY PANEL <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> Adenovirus Coronavirus 229E Coronavirus HKU1 Coronavirus NL63 Coronavirus OC43 Human Metapneumovirus A/B Influenza A Influenza A Subtype H1 Influenza A Subtype H3 Influenza A Subtype H1N1/2009/pdm09 Influenza B </td> <td style="width: 50%; border: none;"> Parainfluenza Virus 1 Parainfluenza Virus 2 Parainfluenza Virus 3 Parainfluenza Virus 4 Human Rhinovirus/Enterovirus Respiratory Syncytial Virus A/B Bordetella Pertussis Chlamydomphila Pneumoniae Mycoplasma Pneumoniae SARS-CoV-2 </td> </tr> </table>	Adenovirus Coronavirus 229E Coronavirus HKU1 Coronavirus NL63 Coronavirus OC43 Human Metapneumovirus A/B Influenza A Influenza A Subtype H1 Influenza A Subtype H3 Influenza A Subtype H1N1/2009/pdm09 Influenza B	Parainfluenza Virus 1 Parainfluenza Virus 2 Parainfluenza Virus 3 Parainfluenza Virus 4 Human Rhinovirus/Enterovirus Respiratory Syncytial Virus A/B Bordetella Pertussis Chlamydomphila Pneumoniae Mycoplasma Pneumoniae SARS-CoV-2	J06.9 Acute Upper Respiratory, Unspecified J00 Acute Nasopharyngitis J22 Acute Lower Respiratory J01.90 Acute Sinusitis, Unspecified J98.9 Respiratory Disorder, Unspecified J02.9 Acute Pharyngitis, Unspecified R05.9 Cough, unspecified R06.2 Wheezing R50.9 Fever, unspecified Z57.9 Occupational exposure to unspecified risk factor Z03.818 possible exposure to COVID 19 Z20.828 actual exposure COVID 19 B99.9 Unspecified Infectious Disease _____ _____ _____
Adenovirus Coronavirus 229E Coronavirus HKU1 Coronavirus NL63 Coronavirus OC43 Human Metapneumovirus A/B Influenza A Influenza A Subtype H1 Influenza A Subtype H3 Influenza A Subtype H1N1/2009/pdm09 Influenza B	Parainfluenza Virus 1 Parainfluenza Virus 2 Parainfluenza Virus 3 Parainfluenza Virus 4 Human Rhinovirus/Enterovirus Respiratory Syncytial Virus A/B Bordetella Pertussis Chlamydomphila Pneumoniae Mycoplasma Pneumoniae SARS-CoV-2		

RESULTS SENT TO:

Physician's Portal
 FAX
 EMAIL

REQUESTING PROVIDER SIGNATURE

I hereby authorize Certivia Laboratories to perform the indicated tests on this patient requisition form.

Physician Signature: _____ Date: _____