ProPhase DIAGNOSTICS

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All samples received may be processed by
ProPhase Diagnostics' New York satellite location
(711 Stewart Ave, Garden City NY, 11530)

Account Info:_____

DOH REQUIRED INFORMATION (ANY OMISSION MAY RESULT IN DELAY OF REPORT)

PATIENT INFO

Last Name: First Name: M.I: Date of Birth: mm dd yy Sex: ◯M ◯F ◯ OTHER

Street Address: Suite, Apt, PO Box, etc. Phone:

City: State: Zip Code: Email:

SAMPLE INFO

Race/Ethnicity: Collection Date: mm dd yy Time: am pm Specimen Type: ◯ Nasopharyngeal/Nasal Swab ◯ Saliva ◯ Sputum

Employer/School: Reoccuring: ◯ Yes ◯ No Date of Previous Test: mm dd yy Date of Influenza Vaccination (if any): mm dd yy

Employer/School Address: Date of Onset Symptoms (if any): mm dd yy Time: ◯am ◯pm Date of Surgery:_____ ◯ STAT

INSURANCE/ BILLING INFO

Primary Insurance: ID No: Group No:

Name on Card (Subscriber): Relationship: Subscriber DOB: mm dd yy

Secondary Insurance: ID No: Group No:

Name on Card (Subscriber): Relationship: Subscriber DOB: mm dd yy

Direct Bill/ Billing Contact: Billing Address:

Bank Name: Bank Contact Phone/Email: Bank Account Number:

ANY ASYMPTOMATIC PATIENT SHOULD ONLY HAVE SARS-CoV (COVID-19) TESTING PERFORMED.
If the patient is asymptomatic and seen by a qualified physician in a healthcare setting, then a SARS-CoV-2 (COVID-19) test with a reflex to the Respiratory Pathogen Panel may be appropriate as determined and ordered by the healthcare provider. Prophase Diagnostics does NOT support the use of our Respiratory Pathogen Panel on asymptomatic patients. Prophase Diagnostics encourages responsible utilization of these vital tests, now and at all times.

☐ **COVID-19 (SARS-CoV-2) by RT-PCR**

SARS-CoV-2 (N gene, S gene, ORF1ab gene)

☐ **Reflex to Respiratory Pathogen Panel by RT-PCR**

If **SARS-CoV-2** is not detected then reflex to Respiratory Pathogen Panel by RT-PCR

☐ **Respiratory Pathogen Panel by RT-PCR**

Viral Targets
Influenza A (A, H1-2009, H3)
Influenza B
Influenza C
Parainfluenza (1,2,3,4)
Common Cold Panel
Adenovirus
Human Bocavirus
Human Coronavirus (HKU1, NL63, 229E, OC93) Human Enterovirus
Human Rhinovirus
Human Parechovirus
Respiratory Syncytial Virus A/B
Human Metapneumovirus A/B
SARS (Severe Acute Resp Syndrome)
MERS (Middle East Resp Syndrome)
SARS-CoV-2

Bacterial Targets
Mycoplasma Pneumoniae
Chlamydia Pneumoniae
Streptococcus Pneumoniae
Klebsiella Pneumoniae
Haemophilus Influenza/Type B
Legionella pneumophila/longbeachae
Moraxella Catarrhalis
Coxiella Burneti
Bordetella Pertussis
Bordetella Parapertussis
Bordetella Holmesii
Group A Strep
Group B Strep
Group C & G Strep
MRSA (S. aureus, mec A)

Fungal Targets
Pneumocystis Jirovecii

ICD-10 CODES

Chart notes must reflect diagnosis selected. Commonly used codes are listed below as a convenience. Check all codes that apply.

- ○ Z20.822 Known or suspected exposure
- ○ A49.9 Bacterial infection, unspecified site
- ○ J11.1 Flu due to unidentified Flu virus
- ○ J01.90 Acute sinusitis, unspecified
- ○ J06.9 Acute Upper Respirtory Infection, unspecified
- ○ Z20.828 Contact with suspected exposure to other viral communicable diseases
- ○ Z20.818 - Contact with and (suspected) exposure to other bacterial communicable diseases
- ○ R05 Cough
- ○ R06.02 Shortness of breath
- ○ R 50.9 Fever, unspecified
- ○ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out

This specimen was provided voluntarily for analysis and I authorize the laboratory to process, bill and provide results. I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Prophase Diagnostics.

I agree to the declarations and terms in the patient acknowledgment and irrevocable assignment of benefits. I understand that if I do not have insurance, I will be billed directly by Prophase Diagnostics. I also authorize release of my results to my doctor utilizing all methods of transmission according to HIPAA regulations. De-identified patient data may be used for R&D purposes.

SIGN HERE Patient:

ORDERING PROVIDER ATTESTATION

○ _____ ○ _____
○ _____ ○ _____
○ _____ ○ _____

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

SIGN HERE Ordering Provider: Date: