

Clinic/Facility Name: _____
 Account #: _____
 Provider(s): _____
 Physician Name: _____ NPI #: _____



1 Industry Drive, Henderson, NC 27537
 Phone: (252) 572-2795
 Fax: (252) 572-4595
 CLIA ID: 34D2141858



Information highlighted in RED is required. Attach a copy of patient ID & insurance card.

COVID-19 REQUISITION

1. Patient Demographics

Last Name: _____		First Name: _____		MI: _____	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Multi-Race <input type="checkbox"/> Native Hawaiian of Other Pacific Islande <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refused to Answer
Date of Birth: _____		Social Security #: _____			
Address: _____		City/State/Zipcode: _____			
Phone #: _____		Email Address: _____			
Guardian: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other (In Loco Parentis) Phone #: _____					
Last Name: _____		First Name: _____		MI: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		

2. Specimen Collection Information

Collector Name: _____	Collection Date: ____ / ____ / ____
Collection Time: _____	Collection Procedure: <input type="checkbox"/> Nasal <input type="checkbox"/> Oral <input type="checkbox"/> Nasopharyngeal

Do not order non-medically necessary tests

3. Test Selection and Diagnosis Code Selection

TEST TYPE: PCR ANTIBODY ANTIGEN

720100 COVID-19 SARS-COV-2 by RT-PCR U0003

COVID-19 DX CODES

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> R05
Cough | <input type="checkbox"/> R50.9
Fever, unspicifc | <input type="checkbox"/> Z03.818
Encounter for observation for suspected exposure to other biological agents ruled out
<i>For cases where there is a concern for possible COVID-19 exposure</i> | <input type="checkbox"/> Z20.828
Contact with and (suspected) exposure to other viral communicable diseases.
<i>Only to be used if actual exposure with someone confirmed to have COVID-19</i> |
| <input type="checkbox"/> R06.02
Shortness of Breath | <input type="checkbox"/> Z11.59
Encounter for screening for other viral diseases | | |

Consent/Insurance Release: I, the undersigned, understand and grant permission to Mako Medical Laboratories, LLC to bill my insurance for laboratory services provided. I understand that services provided may not be covered by my insurance. I further understand that I may be responsible for co-pays, deductibles, and any amount not covered by my insurer. By signing below, I acknowledge that payment may be made on my behalf to Mako Medical Laboratories, LLC. I hereby authorize the ordering physician and/or clinic to disclose any personal or medical information that may be needed to process claims related to services rendered by Mako Medical Laboratories, LLC and its affiliates including information that pertains to my participation in substance abuse treatment. I understand that my records may be protected under 42 CFR Part 2, under which I may revoke my consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires six (6) months after the date of program discharge.

Patient Signature: _____ Patient Signature On File

Provider Signature: _____