Ayass bioscience LLC™
Bridging Science and Precision Patient Care

COVID-19 Testing Requisition

1. PATIENT INFORMATION

Last Name | First Name | MI

Address

City | State | Zip

Phone | Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female

Ancestry ☐ Caucasian ☐ Eastern European ☐ Northern European ☐ Western European ☐ Native American ☐ Middle Eastern ☐ African American ☐ Asian ☐ Pacific Islander ☐ Caribbean ☐ Central/South American ☐ Other: ______ ☐ Ashkenazi Jewish ☐ Hispanic

Email

IS A QR CODE REQUIRED ON THE TEST REPORT? (E.G. for travel) ☐ YES ☐ NO

2. PROVIDER INFORMATION

Clinic Name

Physician Name | NPI#

Address

City | State | Zip | Phone

Fax | Email

3. SPECIMEN COLLECTION

Specimen Type ☐ Sputum ☐ Nasopharyngeal Swab | Date of Collection (mm/dd/yyyy) | Time of Collection (HH:MM) ☐ AM ☐ PM

Pack and ship suspected and confirmed SARS-CoV-2 patient specimens, cultures, or isolates as UN 3373 Biological Substance, Category B, in accordance with the current edition of the International Air Transport Association (IATA) Dangerous Goods Regulations external icon. Personnel must be trained to pack and ship according to the regulations and in a manner that corresponds to their function-specific responsibilities.

4. BILLING INFORMATION

BILL: ☐ Insurance ☐ Medicaid ☐ Medicare ☐ Self Pay ☐ Worker's Compensation ☐ Uninsured

Name of Policyholder | DOB (mm/dd/yyyy) | Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependant ☐ Other______

Insurance | Member ID# | Group#

5. COVID-19 TEST

ICD-10 DIAGNOSIS CODES: ______

☐ **COVID-19**
SARS-CoV-2 by RT-PCR

6. ICD-10

- ☐ J80____Acute respiratory distress syndrome (ARDS)
- ☐ J20.8__Acute bronchitis due to other specified organisms
- ☐ J22____Unspecified acute lower respiratory infection
- ☐ J12.89_Other viral pneumonia
- ☐ J98.8__Other specified respiratory disorders
- ☐ R05___Cough
- ☐ R06.02__Shortness of breath
- ☐ R50.9___Fever, unspecified
- ☐ Z20.828_Contact with and (suspected) exposure to other viral communicable diseases
- ☐ Z03.818__Encounter for observation for suspected exposure to other biological agents ruled out
- ☐ B97.29__Other coronavirus as the cause of diseases classified elsewhere

7. QUESTIONNAIRE

ALL INFORMATION IS STRICTLY CONFIDENTIAL AND IS FOR USE WHEN DIAGNOSING ILLNESS AMONG MEMBERS OF YOUR COMMUNITY

State if you have following symptoms:

1. Have you traveled internationally within 14 days? ☐ NO ☐ YES
2. Have you come into close contact with someone who has a laboratory confirmed COVID-19 diagnosis? ☐ NO ☐ YES
3. Do you have a fever (greater than 100.4 F or 38.0 C)? ☐ NO ☐ YES How long ______

Do you have symptoms of lower respiratory illness:

4. Cough ☐ NO ☐ YES How long ______
5. Shortness of breath ☐ NO ☐ YES How long ______
6. Dificulty breathing ☐ NO ☐ YES How long ______

State if you have following conditions:

7. Diabetes mellitus ☐ NO ☐ YES
8. Asthma/COPD ☐ NO ☐ YES
9. Cancer ☐ NO ☐ YES
10. Immunodeficiency ☐ NO ☐ YES
11. Smoking ☐ NO ☐ YES ☐ QUIT
12. Allergies ☐ NO ☐ YES If "YES" Explain ______
13. Medications ☐ NO ☐ YES If "YES" List ______

8. PATIENT CONSENT

Billing ABN and Patient Plan Information: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing. This does not apply to specific site analyses. Insurance pre-qualification will not be performed for these tests, unless specifically requested. All tests ordered shall be processed and billed based on payor.
Patient Acknowledgment: I am covered by insurance and authorize Ayass BioScience, LLC to give my designated insurance carrier(s) plan on this form and other information provided by my health care provider necessary for reimbursement. I authorize Ayass BioScience, LLC to inform my Plan of my test results only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to Ayass BioScience, LLC. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded immediately to the laboratory.
Patient Consent: My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any other time.
Patient Consent for Research: ☐ By checking this box I DO NOT consent for the remaining part of my sample to be used for research purposes by Ayass BioScience, LLC. Personal information will not be shared and will be kept confidential by Ayass BioScience, LLC.
If Signature is other than patient's.

Printed Name______

(mm/dd/yyyy)

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE | DATE

9. MEDICAL NECESSITY FOR TESTING

This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome, or disorder, and these results will be used in the medical management and treatment for this patient. Furthermore, recipients' information is true and correct to the best of my knowledge.
Please send report to: ______

HEALTH CARE PROVIDER'S SIGNATURE | DATE

TEST SUBMISSION CHECKLIST

- ☐ Copy of Patient Demographics
- ☐ Current Meds List
- ☐ ICD-10 Diagnosis Codes
- ☐ Patient's/Provider's Signatures
- ☐ Copy of Insurance Card (Front/Back)
- ☐ Attach Patient's Insurance Pre-Authorization Form

Collected by: ______

______ Signature

Covid-19-RF-V10