

BILLING INFORMATION	PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	PLEASE ATTACH A COPY OF PATIENT ID
	PATIENT ADDRESS		CITY	STATE	ZIP CODE
	BILL TO: <input type="checkbox"/> FACILITY <input type="checkbox"/> PATIENT <input type="checkbox"/> INSURANCE <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE ** ATTACH ABN FORM		INCLUDE ALPHA CHARACTERS		
	<input type="checkbox"/> PATIENT UNINSURED, BILL HRSA If HRSA is selected, enter Social Security No. _____ or Driver's License No. (REQUIRED): _____				
	PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME		
	INSURED NAME		RELATIONSHIP	INSURED NAME	
	MEMBER ID/GROUP		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	RELATIONSHIP	
	INSURED ADDRESS		MEMBER ID/GROUP		
DATE COLLECTED		TIME COLLECTED	COLLECTED BY		
		<input type="checkbox"/> AM <input type="checkbox"/> PM	WRITE PATIENT'S NAME ON ALL SPECIMENS		

CLINIC INFORMATION: ID / NAME	
ADDRESS	
CITY, STATE	ZIP
PHONE	FAX
PROVIDER ID / NAME	
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
PROVIDER SIGNATURE	

PATIENT AUTHORIZATION

SIGNATURE REQUIRED

I certify that I have voluntarily provided specimen for analytical testing. The information provided on this form and on the specimen container is accurate. I authorize Simple Laboratories to release the results of this testing to the treating physician or facility. I hereby authorize my insurance benefits to be paid directly to Simple Laboratories for services I received. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse the insurance check and forward it to Simple Laboratories within 30 days of the receipt. Simple Laboratories will make every effort to seek reimbursement from third-party payors and governmental programs if patient would like their insurance billed. In the event my insurance is out of network with Simple Laboratories, and they will not pay Simple Laboratories for the services incurred on this requisition, I agree to pay for these services at Simple Laboratories published patient prices for these services. Failure to do so may result in my account being forwarded to collections and reported to a credit bureau. Simple Laboratories is not in network with Aetna, Cigna, or Humana. I understand that Simple Laboratories may use the specimen and any testing performed on that specimen, for research, development, and potential publication purposes, so long as the information has been properly de-identified pursuant to the law. I understand Federal legislation enacted in March 2020 requires comprehensive private health insurance plans to cover this test and provides funds for reimbursement to providers for COVID-19 testing for uninsured patients. By choosing to pay out-of-pocket, I am electing not to seek reimbursement through this mechanism. If "Bill HRSA" is selected above, I hereby attest that I do not have insurance (either through an employer, private, or marketplace), Medicaid, Medicare, or any other form of healthcare reimbursement coverage.

<b>PROFILES</b> PROFILES ARE MADE FOR PROVIDER CONVENIENCE. PROVIDER CAN ORDER INDIVIDUAL TESTS OR REQUEST CUSTOM PROFILES	
<b>SWAB / Source:</b>	
<input type="checkbox"/> Nasopharyngeal (NP) Swabs	<input type="checkbox"/> 061031 / COVID-19, RT PCR
<input type="checkbox"/> Oropharyngeal (OP) Swabs	<input type="checkbox"/> 061033 / INFLUENZA A + B + COVID-19, RT PCR
<input type="checkbox"/> Sputum	<input type="checkbox"/> 061032 / INFLUENZA A + B, RT PCR
<input type="checkbox"/> Anterior Nasal	
<b>SERUM / Yellow Top</b>	<input type="checkbox"/> 013013 / COVID-19 IGG AND IGM
	<input checked="" type="checkbox"/> BF / PROCESSING FEE (For Simple Laboratories Collectors Only)
	<input type="checkbox"/> 013014 / SARS-COV-2 IGG
	<input type="checkbox"/> 013015 / SARS-COV-2 IGM

PROVIDER MEDICAL NECESSITY NOTICE: Only tests that are medically reasonable and necessary for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. The Office of the Inspector General takes the position that a provider who orders medically unnecessary tests for with Medicare or Medicaid reimbursement is claimed may be subject to penalties under the False Claims Act.

**DIAGNOSIS CODES (✓)** The following diagnosis codes are listed as a convenience only. Ordering providers should use the ICD-10 code that best describes the reason for performing the test, whether or not that code is listed below.

<b>RESPIRATORY:</b>	<b>COVID-19:</b>
J20.9 <input type="checkbox"/> Acute bronchitis, unspecified	B34.2 <input type="checkbox"/> Coronavirus infection, unspecified
J05.0 <input type="checkbox"/> Acute obstructive laryngitis (croup)	B97.29 <input type="checkbox"/> Other coronavirus as the cause of dis. classified elsewhere
J06.9 <input type="checkbox"/> Acute upper respiratory infection, unspecified	U07.1 <input type="checkbox"/> COVID-19
J00 <input type="checkbox"/> Common Cold	Z03.818 <input type="checkbox"/> Encounter for observation for suspected exposure to other biological agents ruled out
Z11.2 <input type="checkbox"/> Encounter for screening for other bacterial dis.	Z20.828 <input type="checkbox"/> Contact with and (suspected) exposure to other viral communicable dis.
Z11.8 <input type="checkbox"/> Encounter for screening for other infectious & parasitic dis.	
Z11.59 <input type="checkbox"/> Encounter for screening for other viral diseases	
A49.3 <input type="checkbox"/> Mycoplasma infection, unspecified	
B96.0 <input type="checkbox"/> Mycoplasma pneumoniae as cause of dis. classified elsewhere	
J22 <input type="checkbox"/> Unspecified, acute lower respiratory infection	
J42 <input type="checkbox"/> Unspecified, chronic bronchitis	

ADDITIONAL DIAGNOSIS:

CBT/MUT INITIALS

---

**FOR LAB USE ONLY**

SIMPLE LABORATORIES