Molecular Vision Laboratory Requisition

Coronavirus Disease
(COVID-19)
Virus Testing

PRIMARY PATIENT

LAST NAME	FIRST NAME
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ○ Male ○ Female ○ Unknown
MED REC#/PATIENT IDENTIFIER	ETHNICITY
ADDRESS	

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	EMAIL

SAMPLE TYPE	SAMPLE COLLECTION DATE (MM/DD/YYYY)
○ SALIVA ○ NASOPHARYNGEAL	

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME	PROVIDER FIRST NAME

NPI (USA)	MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PROVIDER PHONE	FAX REPORT TO

GC/PRIMARY CONTACT	GC/PRIMARY CONTACT PHONE/EMAIL/FAX

I have read the Informed Consent document and I give permission to Molecular Vision Laboratory to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Molecular Vision Laboratory and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.mvisionlab.com/policies/privacy-policy.

☐ Opt out of research

☐ Check this box if you are a New York state resident and give permission for mvisionlab to retain any remaining sample longer than 60 days after the completion of testing.

I attest that the patient has received and read the mvisionlab Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Molecular Vision Laboratory Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

ORDERING PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)
X	

TEST REQUESTED

TEST NAME
Coronavirus Disease (COVID-19) Virus Testing

☐ RT-PCR ☐ Antibody testing

SAMPLE REQUIREMENT

a. Collect using standard procedure for selected sample type/kit.
b. Label each specimen with at least two unique identifiers that match the order paperwork (e.g. - patient first and last name; DOB; MRN).
c. Store sample in freezer or refridgerator until shipping
d. Ship samples at ambient temperature within 24 hours of collection

SHIPPING INSTRUCTIONS

Send completed TRF with collected sample to:

Molecular Vision Laboratory,
1920 NE Stucki Ave, Ste. 150, Hillsboro OR 97006,

ICD-10 CODES - Enter ICD-10 code(s) for all tests ordered

☐ Pneumonia (COVID-19)
J12.89 Pneumonia, Other viral pneumonia
B97.29 Pneumonia, Other coronavirus

☐ Lower Respiratory Infection (COVID-19)
J22: Acute lower respiratory infection, Unspecified
B97.29 Pneumonia, Other coronavirus

☐ Acute Bronchitis (COVID-19)
J20.8 Acute Bronchitis, Unspecified
B97.29 Pneumonia, Other coronavirus

☐ Bronchitis (COVID-19)
J40 Bronchitis, Unspecified
B97.29 Pneumonia, Other coronavirus

☐ Z03.818 Suspected exposure to COVID-19

☐ Z20.828 Known Exposure to COVID-19

☐ R05 Cough
☐ R06.02 Shortness of Breath
☐ R50.9 Fever, Unspecified
☐ J01.90 Acute Sinusitis, Unspecified
☐ J02.9 Acute Pharyngitis, Unspecified
☐ J06.9 Acute Upper Respiratory Infection, Unspecified
☐ J18.9 Pneumonia, Unspecified Organism
☐ J20.9 Acute Bronchitis, Unspecified
☐ J32.9 Chronic Sinusitis, Unspecified
☐ Other:

INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

PLEASE ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE	REFERRAL/PRIOR AUTH		By signing above, the patient or insured authorizes to release medical information Molecular Vision Laboratory concerning the test to the assigned insurance company.

PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

INSTITUTION/PRACTICE NAME			
ATTENTION TO			
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	FAX/EMAIL

SELF PAY

○ Use patient information above for billing
○ Use information below for billing

PRIMARY PATIENT

By signing above, the patient or payor authorizes Molecular Vision Laboratory to contact them directly, and use the provided billing instructions to bill the indicated method

PAYOR LAST NAME	PAYOR FIRST NAME
ADDRESS	

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	FAX/EMAIL