



Prorenata Laboratories, LLC

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CLIA# 03D2147626

PATIENT INFORMATION

Last Name: _____ First Name: _____ D.O.B.: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: _____ Sex: M / F (circle one)

SPECIMEN INFORMATION

Date of Collection (MM/DD/YY): _____

FACILITY INFORMATION

Facility Name: _____

- Charge Facility
- Bill Insurance (attach Demo sheet or copy of insurance card)
- Bill Patient (MUST fill out Credit Card authorization form)

PATIENT CONSENT AND AUTHORIZATION:

I supplied accurate and true information with this form. If I supplied insurance information, I authorize payment of my insurance benefits directly to Prorenata Labs or their affiliates. I authorize Prorenata Labs or their affiliates to be my Designated Representative and to appeal any denial of health benefits. I understand Prorenata Labs or their affiliates may be out of network with my plan, and I accept responsibility for paying to Prorenata Labs or their affiliates any amounts my insurer determines are my responsibility after calculating deductibles, co-payments and co-insurance due under my policy. I understand I am legally responsible for sending Prorenata Labs or their affiliates any money received from my health insurance company for performance of this laboratory test. I also allow the release of medical information necessary to process this claim.

PROVIDER AUTHORIZATION TO TEST:

I am authorized to order laboratory tests and hereby order the tests indicated below. I confirm these test(s) are medically necessary for the treatment of the patient. I supplied accurate and true information on this form. I am aware information has been supplied to the patient about drug testing and that the patient has consented to the testing through his/her signature on this form. I understand that it is my responsibility to document medical necessity for testing in the patient record and to provide a copy of the same to Prorenata Labs or their affiliates upon request.

Patient/Guardian Signature

Date

Printed Physician Name

Physician Signature

Date

ICD-10 CODES

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| <ul style="list-style-type: none"> <input type="checkbox"/> A37.90 Whooping Cough <input type="checkbox"/> A37.81 Whooping Cough with pneumonia <input type="checkbox"/> A37.80 Whooping Cough due to Bordetella, bronchiseptica <input type="checkbox"/> A37.81 Whooping Cough due to Bordetella, bronchiseptica, with pneumonia <input type="checkbox"/> A37.10 Whooping Cough due to Bordetella, parapertussis <input type="checkbox"/> A37.11 Whooping Cough due to Bordetella, parapertussis, with pneumonia <input type="checkbox"/> A37.00 Whooping Cough due to Bordetella pertussis <input type="checkbox"/> J01.90 Acute Sinusitis, unspecified <input type="checkbox"/> J02.8 Acute pharyngitis due to other specified organisms <input type="checkbox"/> J02.9 Acute pharyngitis, unspecified <input type="checkbox"/> J03.80 Tonsillitis, acute due to other specified organism <input type="checkbox"/> J03.81 Tonsillitis, acute recurrent due to other specified organism <input type="checkbox"/> J03.90 Tonsillitis, acute unspecified <input type="checkbox"/> J03.91 Tonsillitis, acute recurrent unspecified <input type="checkbox"/> J04.0 Laryngitis, acute <input type="checkbox"/> J04.2 Laryngotracheitis, acute <input type="checkbox"/> J06.9 Upper respiratory tract infection, NOS, acute or subacute <input type="checkbox"/> J06.9 Upper respiratory disease, acute | <ul style="list-style-type: none"> <input type="checkbox"/> J06.9 Infection, Infected respiratory tract, viral NOS <input type="checkbox"/> J11.00 Influenza, unidentified virus, with pneumonia <input type="checkbox"/> J11.1 Influenza, unidentified virus, with other respiratory manifestations <input type="checkbox"/> J11.2 Influenza, unidentified virus, with gastrointestinal manifestations <input type="checkbox"/> J11.83 Influenza, unidentified <input type="checkbox"/> R09.89 Other unspecified symptoms involving the circulatory & respiratory system virus, with otitis media <input type="checkbox"/> J11.89 Influenza, unidentified virus, with other manifestations <input type="checkbox"/> J12.82 Pneumonia due to coronavirus disease 2019 <input type="checkbox"/> J12-J12.9 Viral pneumonia <input type="checkbox"/> J13.J17 Bacterial pneumonia <input type="checkbox"/> J18.0 Bronchopneumonia, unspecified organism <input type="checkbox"/> J18.1 Lobar pneumonia, unspecified organism <input type="checkbox"/> J18.9 Pneumonia, unspecified organism <input type="checkbox"/> J20.9 Acute Bronchitis, unspecified <input type="checkbox"/> J31.1 Chronic nasopharyngitis <input type="checkbox"/> J32.9 Chronic sinusitis, unspecified <input type="checkbox"/> J37.0 Laryngitis, unspecified | <ul style="list-style-type: none"> <input type="checkbox"/> J37.1 Laryngotracheitis, chronic <input type="checkbox"/> J39.9 Disease, diseased, upper respiratory tract <input type="checkbox"/> R05.1 Acute cough <input type="checkbox"/> R05.2 Subacute cough <input type="checkbox"/> R05.3 Chronic cough <input type="checkbox"/> R05.8 Other specified cough <input type="checkbox"/> R05.9 Cough, unspecified <input type="checkbox"/> R06.00 Dyspnea, unspecified <input type="checkbox"/> R06.02 Shortness of breath <input type="checkbox"/> R06.09 Other forms of dyspnea <input type="checkbox"/> R06.1 Stridor <input type="checkbox"/> R06.2 Wheezing <input type="checkbox"/> R06.3 Periodic breathing <input type="checkbox"/> R06.6 Hiccough <input type="checkbox"/> R06.9 Abnormalities of breathing, unspecified <input type="checkbox"/> R06.89 Other abnormalities of breathing <input type="checkbox"/> R07.1 Chest pain <input type="checkbox"/> R07.81 Pleurodynia <input type="checkbox"/> R07.89 Other chest pain <input type="checkbox"/> R07.9 Chest pain, unspecified <input type="checkbox"/> R09.3 Abnormal sputum <input type="checkbox"/> R09.89 Other unspecified symptoms involving the circulatory & respiratory system <input type="checkbox"/> R50.0 Fever, unspecified <input type="checkbox"/> R53.81 Other malaise | <ul style="list-style-type: none"> <input type="checkbox"/> Z20.89 Suspected Exposure <input type="checkbox"/> R09.81 Nasal Congestion <input type="checkbox"/> K20.9 Esophagitis unspecified <input type="checkbox"/> Z20.828 Contact with and (suspected) exposure to other viral communicable diseases <input type="checkbox"/> Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out <input type="checkbox"/> Z11.52 Encounter for screening for COVID-19 <input type="checkbox"/> _____ Other <p>Antibiotic Resistance</p> <ul style="list-style-type: none"> <input type="checkbox"/> Z16.30 Resistance to unspecified antimicrobial drugs <input type="checkbox"/> Z16.31 Resistance to antiparasitic drug(s) <input type="checkbox"/> Z16.32 Resistance to antifungal drug(s) <input type="checkbox"/> Z16.11 Resistance to antiviral drug(s) <input type="checkbox"/> Z16.35 Resistance to multiple antimicrobial drugs <input type="checkbox"/> Z16.39 Resistance to other specified antimicrobial drugs <input type="checkbox"/> Z16.341 Resistance to single antimycobacterial drug <input type="checkbox"/> Z16.342 Resistance to multiple antimycobacterial drugs |
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COVID-19

COVID-19 IF NEGATIVE RUN THE BELOW SELECTED TEST(S)

RESPIRATORY PANEL

Viral Targets

Influenza A
Influenza B

RSV A/B
COVID-19