Cleveland Clinic Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

CORONAVIRUS 2019 (COVID-19) TEST REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name ______ First ______ MI ______

Address ______ Birth Date ______ Sex ☐ M ☐ F

City ______ County ______ SS # ______

State ______ Zip ______ Home Phone ______

Hospital/Physician Office Patient ID # ______ Accession # ______

ETHNICITY: ☐ Unknown (;Z) ☐ Hispanic (;H) ☐ Non-Hispanic (;N) ☐ Other (;O)

RACE: ☐ Unknown (;Z) ☐ White (;W) ☐ Black (;B) ☐ Asian (;A) ☐ Native American (;N)

IF PATIENT IS UNDER 16 YEARS OF AGE:

Name of guardian/parent ______

CLIENT INFORMATION

SAMPLE INFORMATION (REQUIRED)

Collection Date: ____/____/____ Time: ______

Collected by: ______

Specimen Type:

☐ Nasopharyngeal (NP) Swab ☐ Bronchoalveolar lavage (BAL)
☐ Oropharyngeal (OP) Swab ☐ Sputum

PLEASE COMPLETE THE FOLLOWING SECTION WHEN A COPY OF INSURANCE CARD (FRONT AND BACK) IS NOT PROVIDED.

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

SECONDARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

PHYSICIAN INFORMATION (REQUIRED)

Physician Signature ______

Date / Time ______

Physician Name (please print) ______

Address ______

City, State, Zip ______

Phone ______ UPIN ______

☐ Send additional report

Physician: ______

Address: ______

City, State, Zip: ______

☐ Call Results to phone number: (______) ______

☐ Fax report to: (______) ______

BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)

BILL TO: ☐ Client ☐ Patient ☐ Medicare ☐ Other Insurance

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes

1. ______ 2. ______ 3. ______

MEDICAL NECESSITY NOTICE

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INDICATE TESTS REQUESTED

☐ 2019 Novel Coronavirus (COVID-19), NAA SARS CoV2 *CORONA*

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