

Site ID:
Site Location:
Site Address:

COVID-19 by PCR Requisition Form

No other test may be ordered on this COVID-19 by PCR requisition form
WRITE LEGIBLY!

Ordering Physician: Dr. Erica Schwartz, MD Ordering Physician NPI: 1427034826 Quest Account Number: 73916469 LabCorp Account Number: 32044780 Result to: <u>Maximus</u>	CPT Code: 87635 Test Name: COVID-19 by PCR Sample Type (circle one): Anterior Nares, Foam ICD-10 Code: Z03.818
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1. DATE of Collection (MM/DD/YYYY)

2. TIME of Collection

/ /2020	
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3. LAST NAME

4. FIRST NAME

5. DATE of BIRTH (MM/DD/YYYY)

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6. SEX

7. LANGUAGE

8. RACE

9. ETHNICITY

<ul style="list-style-type: none">• Male• Female	(if not English)	<ul style="list-style-type: none">• Asian• Black• White• Unknown• Other	<ul style="list-style-type: none">• American Indian/ Alaska Native• Native Hawaiian/ Other Pacific Islander• Not Specified	<ul style="list-style-type: none">• Hispanic/Latino• Non-Hispanic/Latino• Not Specified
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10. ADDRESS

11. CITY

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12. STATE

13. ZIP CODE

14. PHONE NUMBER (primary)

		Cell / Home
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15. INSURANCE CARRIER NAME

16. GROUP NUMBER

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17. MEMBER/INDIVIDUAL NUMBER

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Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode [should match the Barcode on the specimen tube]