NCF | Diagnostics & DNA Technologies

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ORDERING CHECKLIST

1. Sample Collection Date
2. Patients Name with a copy of Demographic/FACE sheet
3. Check appropriate panel type
4. Copy of Patient's insurance card (Front and Back)
5. Applicable diagnosis codes (Medical Necessity)
6. Provider note documenting ordering of test and utilization of results
7. Medical Provider name and signature.

Respiratory Test Requisition (Blue Selection Required)

****Missing Information may delay turn around time****

Patient Information (ALL REQUIRED)

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Last Name First Name MI

Date of Birth Biological Sex

Address

City State Zip Phone

Ancestry ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ Ashkenazi Jewish ☐ Other_______________

Practice Information

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Practice Name

Address

City State Zip

Phone Fax

Physician Name NPI #

Billing Information

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Billing Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Tricare ☐ Cash Pay

Primary Insurance Member ID # Group # Effective Date

Primary Insured (self,spouse,other) Phone # DOB Insured

Secondary Insurance Member ID # Group # Effective Date

Secondary Insured (self,spouse,other) Phone # DOB Insured

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☐ **COVID-19**

SARS-COV-2

☐ **Comprehensive RespiraPath Panel**

Viruses	Bacteria	ResistantPath
❒ Adenovirus	❒ Bordetella pertussis	❒ mecA Gene
❒ Coronavirus 229E	❒ Chlamydia pneumoniae	❒ mcr-1 Gene
❒ Coronavirus HKU1	❒ Haemophilus influenzae	❒ sul1 Gene
❒ Coronavirus NL63	❒ Moraxella catarrhalis	❒ tetM/tetS Gene
❒ Coronavirus OC43	❒ Mycoplasma pneumoniae	❒ vanA/vanB Gene
❒ Enterovirus	❒ Staphylococcus aureus	
❒ Human Bocavirus	❒ Streptococcus pneumoniae	
❒ Human Metapneumovirus	❒ Streptococcus pyogenes	
❒ Influenza A		
❒ Influenza A H1		
❒ Influenza A H3		
❒ Influenza B		
❒ Parainfluenza 1		
❒ Parainfluenza 2		
❒ Parainfluenza 3		
❒ Parainfluenza 4		
❒ Respiratory Syncytial Virus A		

AUTOMATIC REFLEX: A laboratory test that is automatically obtained when the results of a screening test indicate the need for further study. The outcome of the first test will determine if reflex testing is needed for any particular pathogen gene(s). If SARS-COVID-19 results in anything other then positive the sample will be reflexed to Comprehensive RespiraPath Panel.

☐ **Do not reflex any results.**

SPECIMEN INFORMATION

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☐ Nasopharyngeal Swab

☐ Oropharyngeal Swab

Date of Collection (MM/DD/YY)

SPECIMEN INFORMATION (Continued)

Collection Time ☐ AM ☐ PM

Initials of Individual Collecting Specimen

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ICD-10 CODES

__________ __________ __________

__________ __________ __________

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

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By signing this form, the medical provider acknowledges that the individual/family member authorized to make decisions for the individual (the "patient") has consented to undergo pathogen testing. This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder; and has been assigned the applicable ICD 10 codes as a result. The results will determine my patient's medical management and treatment decisions. I indicate that I am the referring physician or authorized health care provider, and have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek further counsel. I acknowledge and understand that NCF DNA will perform laboratory testing for my patient and sometimes this laboratory may be considered an out-of-network provider. I acknowledge that I am solely responsible for adhering to any applicable policies, procedures and or protocols for the referral of specimens to an out-of-network laboratory established by commercial payers, with whom I or my practice may be contracted. I have made my patient aware of the potential of NCF DNA being an out of network provider and gave the patient the ability to deny the test until a in-network lab provider could be selected. The patient has voluntarily consented to have the test performed by NCF DNA. I acknowledge that I and the patient have been informed and agree, that tests ordered are not a guarantee of coverage and payment of the test is subject to individual plan benefits. If the test is not covered in full by the insurer for any reason, NCF DNA reserves the right to bill the patient directly for services rendered.

By checking the box the patient opts out of de-identified research purposes. ☐

Medical Provider Signature **Date**

COVID-19 / RespiraPath Request Form Guide

IMPORTANT DETAILS

- Two patient identifiers are required on each specimen. If the patient identification sticker includes a barcode, the patient's date of birth must be added to the label. If no barcode is present, the patient's first name, last name and date of birth must be provided. The identifiers on the specimen must match the identifiers on the laboratory requisition. Specimens that do not contain these identifiers will be rejected. Please note: the patient's date of birth must always be provided.

Lab Request Form Guide

1. Three patient identification stickers are provided in the specimen kit. One must be placed on the lab request form (in the area labeled #1 on this training guide) and one must be placed on each of the tubes containing the specimen.

2. The patient's name and date of birth must be filled out on form. The date of birth provided on the form must match the information provided on both bar codes. Otherwise, the specimen may be rejected. Attach a face sheet (demographic page) to provide the other data. If a face sheet is not included, the patient's address is required.

3. An ordering physician/NPI# must be provided so that the report can be delivered. Once the NCF DNA account enrollment form is filled out and sent in, the information provided will be pre-populated in the matching fields.

4. This section can be left blank if either a photocopy of the insurance card (both sides) or a face sheet with the current billing information is included.

5. The specimen collection type, date, time and collector's initials are required. Failure to provide this information may result in reporting delays.

6. The provider is required to make a test panel selection. Any sample missing a test selection will be rejected.

7. ICD-10 codes are required for billing. Failure to provide these codes may result in delayed reporting and/or billing. Please ensure that all ICD-10 Codes listed on the requisition form are representative of the patient being seen, as well as his/her health considerations. For a comprehensive listing, please refer to the most recent ICD-10 coding manual. Ultimately, the assignment of the proper diagnosis code(s) is the responsibility of the ordering physician.

8. A physician's signature is required for a specimen to be processed, or for claims to be billed. If the physician's signature is not on the requisition form, the specimen reporting and billing process will be delayed until the signature is obtained.