Location Name: Tri-Health (Miami Students)

SPECEMIN INFORMATION: Date & Time Collected _____ Collected By _____

SPECIMEN TYPE: ☐ Nasopharyngeal Swab ☐ Throat Swab ☐ Urine ☐Genital Swab ☐ Serum ☐Other: _____

SITE: #_____

GRAVITYDIAGNOSTICS™

632 Russell St. ~ Covington, KY 41011
PH: 855-841-7111 CLIA# 18D1100471
Lab Director: Marc Rumpler, PhD.

PATIENT INFO

Last Name	First Name:	☐M ☐F
Address:		
City/State/Zip		
D.O.B. MM/DD/YYYY	Phone:	

PAYMENT INFO

Bill: ☐ Patient Insurance ☐ Facility/Practice Direct Bill Contract ☐ State Bill (COVID-19 ONLY) ☐ Patient Prepayment (CC Auth Form or Check)

For Patient Insurance (A legible copy of patient's insurance card(s) front & back is required.)

Carrier:

Policy #:

Group #:

Ship Sample, demographic information, copy of insurance card(s), copy of driver's license (if available) and this requisition form.

TESTING OPTIONS

☐ **Upper Respiratory Testing -** Performed w/ E swab

☐ **Viral Targets**

- ☐ Adenovirus
- ☐ Influenza A
- ☐ Influenza B
- ☐ Human Enterovirus
- ☐ Human Metapneumovirus A/B
- ☐ Human Rhinovirus
- ☐ Influenza A/H1-2009 (H1N1)
- ☐ Influenza A/H1 - Seasonal
- ☐ Influenza A/H3 - Seasonal
- ☐ Parainfluenza Virus 1, 2, 3, 4
- ☐ Respiratory Synctial Virus A/B
- ☐ Coronavirus HKU1
- ☐ Coronavirus NL63
- ☐ Coronavirus 229E
- ☐ Coronavirus OC43
- ☐ Influenza C
- ☐ Bocavirus
- ☐ Parechovirus

☐ **Bacterial Targets**

- ☐ Streptococcus pyogenes
- ☐ Mycoplasma pneumoniae
- ☐ Chlamydia pneumoniae
- ☐ Haemophilus influenzae B
- ☐ Klebsiella pneumoniae
- ☐ Moraxella catarrhalis
- ☐ Streptococcus pneumoniae
- ☐ Legionella pnuemophila/ longbeach
- ☐ Staphylococcus aureus
  - ☐ Reflex MRSA
- ☐ Salmonella Spp
- ☐ Bordetella Spp
- ☐ Haemophilus influenzae

Fungal Targets

- ☐ Pneumocystis Jirovecii (F)

CORONAVIRUS (COVID-19)

☐ **SARS-CoV-2 RT-PCR** - Performed w/ E swab

☐ **SARS-CoV-2 IgG antibodies** - Performed w/ Serum

- ☐ R05 Cough
- ☐ R50.9 Fever unspecified
- ☐ R06.02 Shortness of breath
- ☐ R43.9 Unspecified disturbances of smell and taste
- ☐ R07.0 Pain in throat
- ☐ R68.83 Chills (without fever)
- ☐ M79.1 Myalgia, unspecified site (muscle pain)
- ☐ U07.1 COVID-19, virus identified
- ☐ Z09 Encounter for follow-up exam after completed treatment
- ☐ Z86.19 Personal history of other infectious diseases
- ☐ Z01.84 Encounter for antibody response
- ☐ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- ☐ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out
- ☐ Other:_____

☐ **Sexually Trans. Infection** (Perfomed w/E swab or urine)

- ☐ Herpes Simplex Virus 1 & 2
- ☐ Gardnerella Vaginalis
- ☐ Ureaplasma urealyticum
- ☐ Candida albicans (e-swab only)
- ☐ Mycoplasma genitalium
- ☐ Treponema pallidum (syphilis)
- ☐ Leukorrhea Panel (Including)
  - ☐ Trichomonas Vaginalis
  - ☐ Neisseria gonorrhoeae
  - ☐ Chlamydia trachomatis

Please select reason(s) for screening as well as including an ICD10 code for medical necessity.

- ☐ New Patient
- ☐ Annual Screening
- ☐ New sexual partner since last test
- ☐ High risk patient
- ☐ Retesting after treatment
- ☐ Recent travel to high risk destination

ICD-10 Codes

Attention: Federal regulators require that only tests that are medically necessary for diagnosis and treatment of a patient's condition be ordered. ICD-10 code(s) is required to prove medical necessity for the test, and for insurance billing. Please include ONLY codes relating to the tests ordered. ***The below ICD-10 codes are frequently used and are in compliance with CGS LCD. Choose all that apply. If you do not see the appropriate code, please fill in the provided blank spaces***

UPPER RESPIRATORY

Upper Respiratory

- ☐ G93.3 Postviral fatigue syndrome
- ☐ J12.89 Other viral pneumonia
- ☐ J15.9 Unspecified bacterial pneumonia
- ☐ J18.8 Other pneumonia, unspecified organism
- ☐ J18.9 Pneumonia, unspecified organism
- ☐ J20.9 Acute bronchitis, unspecified
- ☐ J40 Bronchitis, not specified as acute or chronic
- ☐ J90 Pleural effusion, not elsewhere classified
- ☐ R05 Cough
- ☐ R06.00 Dyspnea, unspecified
- ☐ R06.02 Shortness of breath
- ☐ R06.2 Wheezing
- ☐ R07.1 Chest pain on breathing
- ☐ R50.81 Fever presenting with conditions classified elsewhere
- ☐ R50.9 Fever, unspecified
- ☐ R51 Headache
- ☐ R53.81 Other malaise
- ☐ R53.83 Other fatigue

STI

STI

- ☐ B34.9 Viral infection, unspecified
- ☐ N34.1 Nonspecific urethritis
- ☐ N34.3 Urethral syndrome, unspecified
- ☐ N76.0 Acute vaginitis
- ☐ N76.1 Subacute and chronic vaginitis
- ☐ N76.89 Other specified inflammation of vagina and vulva
- ☐ R10.2 Pelvic and perineal pain
- ☐ R36.9 Urethral discharge, unspecified
- ☐ R50.9 Fever, unspecified
- ☐ R51 Headache
- ☐ Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- ☐ Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- ☐ Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
- ☐ Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
- ☐ Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester
- ☐ Z72.51 High risk heterosexual behavior
- ☐ Z72.52 High risk homosexual behavior
- ☐ Z72.53 High risk bisexual behavior
- ☐ Z72.89 Other problems related to lifestyle

OTHER

- ☐ _____
- ☐ _____

PATIENT CONSENT and ASSIGNMENT OF BENEFITS:

I request and authorize the CLIA accredited laboratory to perform the above designated test(s) on the sample provided by me. I understand Gravity Diagnostics may use specimen and any testing performed on specimen for research, development, and potential publication purposes so long as the information has been properly de-identified pursuant to law. Assignment of Benefits: I hereby assign all rights and benefits under my health plan and direct payments be made to Gravity Diagnostics, LLC for laboratory services furnished to me by Gravity Diagnostics, which I understand may be a non-participating provide with my health plan. I understand I am responsible for any amount not covered by insurance.

Patient Signature:_____

PROVIDER SIGNATURE and MEDICAL NECESSITY STATEMENT

My signature authorizes the providing laboratory and/or any of its affiliated corporations, owners and or doctors to perform and or reference out to another reference laboratory entity the above check-marked test(s) for the ICD-10 condition(s) identified. I certify based upon this patient's history, symptoms, examination findings and medical record that all ordered tests are medically necessary and understand that Medicare & Medicaid do not cover non-medically necessary screenings. I understand any component of any test may be ordered individually and only tests ordered will be reported on. In following the Centers for Disease Control and Prevention: Core Elements of Outpatient Antibiotic Stewardship guidelines, I am selecting Gravity Diagnostics for my infectious disease testing. Their next day turn-around time of results for their syndromic testing allows our facility to follow the CDC's recommendations of 1) only prescribing antibiotics when needed, and 2) minimizing misdiagnoses or delayed diagnoses leading to underutilization of antibiotics.

Provider Signature: _____ Date:_____

Tri-Health (Miami Students)
__ Susan Bantz NPI: 1447272828