

OFFICE/CLINIC LAB REQUISITION FORM

Date Received: _____ Time: _____ Initials: _____

**Attach patient face sheet or complete all highlighted areas prior to sending to the lab.
*PLEASE CHECK THE BOX NEXT TO REQUESTING PHYSICIAN TO RECEIVE RESULTS***

PATIENT INFORMATION			CLINIC INFORMATION		PHYSICIAN INFORMATION			
Name (First and Last): (Include Face Sheet)			Clinic Name:		<input type="checkbox"/> Physician Name: _____ NPI#: _____			
Date of Birth: (MM/DD/YY)	Gender:	Last 4 of SSN:	Organization ID:		<input type="checkbox"/> Physician Name: _____ NPI#: _____			
Patient CELL Phone:		Patient Email:		Clinic Address:		<input type="checkbox"/> Physician Name: _____ NPI#: _____		
Address:			Clinic Phone:		Clinic Fax:		<input type="checkbox"/> Physician Name: _____ NPI#: _____	
City:		State:	Zip:	Clinic Email:		<input type="checkbox"/> Physician Name: _____ NPI#: _____		

SPECIMEN INFO		DIAGNOSTIC INFORMATION		INSURANCE INFORMATION	
Date Collected: (MM/DD/YY)	Number of Samples:	Primary Diagnosis/Clinical Diagnosis:		Select Bill Insurance or Prepay method:	
Specimen Source:	ICD-10 Codes (common codes on reverse):	Z-Codes (common codes on reverse):		<input type="checkbox"/> Bill my Insurance/Medicare. Must include copies of the front and back of insurance card and/or Patient Demo/Face Sheet. <input type="checkbox"/> Do NOT bill my insurance. I agree to pay the patient pay price of \$249* using the payment information given below.	

Circle Yes/No for all that apply to Patient:

Y/N Previous negative or not significant culture	Y/N Presentation of infection with inconclusive culture result
Y/N Failed course of one or more unsuccessful antimicrobials	Y/N Not for screening purposes and necessary to guide treatment

*For most products (all prices subject to change)

NGS+PCR PANELS (NGS TESTS FOR OVER 57,000 SPECIES)		SAMPLE TYPE (CHOOSE ALL THAT APPLY)		PCR ONLY TESTS (ALL qPCR PANELS LOCATED ON BACK)		SAMPLE TYPE (CHOOSE ALL THAT APPLY)	
<input type="checkbox"/> AFB	<input type="checkbox"/> Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Urine	<input type="checkbox"/> COVID-19	<input type="checkbox"/> Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Saliva	<input type="checkbox"/> Rapid H5	<input type="checkbox"/> Swab	<input type="checkbox"/> ENT	<input type="checkbox"/> Swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL
<input type="checkbox"/> Blood	<input type="checkbox"/> Blood	<input type="checkbox"/> Full STI <input type="checkbox"/> Basic STI	<input type="checkbox"/> Urine <input type="checkbox"/> Semen <input type="checkbox"/> Vaginal Swab <input type="checkbox"/> Rectal Swab	<input type="checkbox"/> Gastrointestinal Panel	<input type="checkbox"/> Stool (in Cary Blair Media)	<input type="checkbox"/> Nail	<input type="checkbox"/> Nail <input type="checkbox"/> Swab
<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Tissue <input type="checkbox"/> Swab <input type="checkbox"/> Fluid	<input type="checkbox"/> HPV	<input type="checkbox"/> Vaginal Swab <input type="checkbox"/> Throat Swab	<input type="checkbox"/> HSV	<input type="checkbox"/> Vaginal Swab <input type="checkbox"/> Throat Swab <input type="checkbox"/> Lesion Swab <input type="checkbox"/> Urine	<input type="checkbox"/> RTI (Lungs)	<input type="checkbox"/> Swab <input type="checkbox"/> Sputum <input type="checkbox"/> BAL
<input type="checkbox"/> UTI/Prostate/Rectal Swab	<input type="checkbox"/> Urine <input type="checkbox"/> Swab <input type="checkbox"/> Semen <input type="checkbox"/> Rectal Swab	<input type="checkbox"/> MRSA Screening	<input type="checkbox"/> Swab <input type="checkbox"/> Tissue <input type="checkbox"/> Other: _____	<input type="checkbox"/> Respiratory Viral	<input type="checkbox"/> Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Saliva	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Vaginal Swab
	Optional add-ons: <input type="checkbox"/> FULL STI <input type="checkbox"/> UA Biomarkers (urine only)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Swab		Optional add-on: <input type="checkbox"/> COVID-19		Optional add-on: <input type="checkbox"/> FULL STI
<input type="checkbox"/> Wound	<input type="checkbox"/> Tissue <input type="checkbox"/> Swab <input type="checkbox"/> Fluid <input type="checkbox"/> Blood						<input type="checkbox"/> Tissue <input type="checkbox"/> Swab <input type="checkbox"/> Fluid <input type="checkbox"/> Blood

PHYSICIAN SIGNATURE

The test ordered is medically necessary for the diagnosis indicated. By signing the requisition, I certify that I have informed consent from the patient as required by any applicable state or federal laws with respect to each test ordered. The physician has obtained informed written consent and conveyed to the patient that his/her insurance may or may not pay for some, or all of, the labs/tests ordered and has verbally acknowledged and accepted responsibility for payment.

No Signature Required (Signature on File) Physician Signature: _____

STOP BEFORE SENDING PLEASE HAVE PATIENT READ & SIGN BELOW

I consent allowing MicroGenDX, its agents, and assignees to contact me by email, phone, and SMS message* communication using any contact information that I have given to MicroGenDX, the physician or facility, for purposes related to my care including treatment, payment, collections, or operations. I authorize MicroGenDX to furnish my designated insurance carrier with the information herein. I authorize benefits to be payable to "MicroGenDX". If my insurer pays me directly, I agree to endorse the check, and forward the payment and corresponding EOB to MicroGenDX within 5 days of receipt. I understand that I am responsible for any amount due after insurance including the full amount if my insurance does not pay or is not contracted with MicroGenDX. Self-pay amounts can be found at www.microgendx.com. Per our refund policy, we will no longer process refunds in the amount of \$9.99 or less. *See microgendx.com for further policy and procedures.

PATIENT SIGNATURE HERE: _____

PAYMENT INFORMATION:

Pay By Check (please attach check to this form)

Credit Card Visa MasterCard Other _____ Card #: _____ Expiration (MM/YY): _____ CVV: _____

