

<b>Date Collected</b>	<b>Time Collected</b>	Was patient fasting? <input type="checkbox"/> YES <input type="checkbox"/> NO	VNP Site
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PATIENT INFORMATION	
<b>Last Name, First Name</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Date of Birth</b>	Social Security Number
Street Address	
City	State Zip
Home Phone	Work Phone

PAYMENT INFORMATION		
<input type="checkbox"/> <b>INSURANCE</b>	<input type="checkbox"/> <b>CLIENT BILL</b>	<input type="checkbox"/> <b>PATIENT (PRE-PAY)</b>
<b>Insurance Name</b>		
<b>Policy ID Number</b>	<b>Group Number</b>	
Policy Holder Name	Date of Birth	
Policy Holder Social Security Number		
Relationship to Patient	Phone Number	
Policy Holder Address		
City	State Zip	
Secondary Insurance		
Policy ID Number	Group Number	
Pre-Payment	<input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD (ONLINE)	
Amount Collected \$	Send Cash or Check in Money Bag Only	
I authorize MHS to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay MHS Labs for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance. <b>SIGNATURE REQUIRED</b>		
<b>Patient/Guarantor</b>	<b>Date</b>	
<b>Signature</b>		

FACILITY INFORMATION	
	Room Number

PROVIDER SIGNATURE & MEDICAL NECESSITY	
<p>Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.</p> <p>I certify that (i) this test / (genetic test when applicable) is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and MHS Labs' Patient Informed Consent. I agree to provide MHS Labs, or its designee, any and all additional information reasonably required for this testing to be performed and billed.</p>	
<b>SIGNATURE REQUIRED</b>	NPI:
Physician Name	
<b>Signature</b>	

SPECIMEN INFORMATION		REQUIRED
<input type="checkbox"/> Nasopharyngeal swab		Other:
<input type="checkbox"/> Nasal mid-turbinate swab		

ICD 10 DX CODES		REQUIRED

<input type="checkbox"/> <b>SARS-CoV-2/COVID19, PCR - P11001</b>	<input type="checkbox"/> SARS-CoV-2/COVID-19																																				
<input type="checkbox"/> <b>INFLUENZA PROFILE, PCR - P11002</b>	<input type="checkbox"/> Influenza A&B																																				
<input type="checkbox"/> <b>BASIC RESPIRATORY PROFILE, PCR - P10013</b>	<input type="checkbox"/> Adenovirus <input type="checkbox"/> Influenza A&B <input type="checkbox"/> Respiratory Syncytial Virus A & B																																				
<input type="checkbox"/> <b>COMPLETE RESPIRATORY PROFILE, PCR - P10000</b>	<table border="0"> <tr> <th>Bacterial</th> <th colspan="3">Viral</th> </tr> <tr> <td><input type="checkbox"/> Bordetella pertussis</td> <td><input type="checkbox"/> Adenovirus</td> <td><input type="checkbox"/> Epstein-Barr virus (EBV)</td> <td><input type="checkbox"/> Parainfluenza 2</td> </tr> <tr> <td><input type="checkbox"/> Chlamydia pneumoniae</td> <td><input type="checkbox"/> Bocavirus</td> <td><input type="checkbox"/> Human herpesvirus 6 (HHV-6)</td> <td><input type="checkbox"/> Parainfluenza 3</td> </tr> <tr> <td><input type="checkbox"/> Haemophilus influenzae</td> <td><input type="checkbox"/> Coronavirus 229E</td> <td><input type="checkbox"/> Human metapneumovirus</td> <td><input type="checkbox"/> Parainfluenza 4</td> </tr> <tr> <td><input type="checkbox"/> Klebsiella pneumoniae</td> <td><input type="checkbox"/> Coronavirus HKU1</td> <td><input type="checkbox"/> Influenza A (Pan)</td> <td><input type="checkbox"/> Respiratory Syncytial Virus A</td> </tr> <tr> <td><input type="checkbox"/> Legionella pneumophila</td> <td><input type="checkbox"/> Coronavirus NL63</td> <td><input type="checkbox"/> Influenza A/H1-2009</td> <td><input type="checkbox"/> Respiratory Syncytial Virus B</td> </tr> <tr> <td><input type="checkbox"/> Mycoplasma pneumoniae</td> <td><input type="checkbox"/> Coronavirus OC43</td> <td><input type="checkbox"/> Influenza A/H3</td> <td><input type="checkbox"/> Rhinovirus</td> </tr> <tr> <td><input type="checkbox"/> Streptococcus aureus</td> <td><input type="checkbox"/> Cytomegalovirus</td> <td><input type="checkbox"/> Influenza B</td> <td><input type="checkbox"/> Varicella zoster virus (VZV)</td> </tr> <tr> <td><input type="checkbox"/> Streptococcus pneumoniae</td> <td><input type="checkbox"/> Enterovirus</td> <td><input type="checkbox"/> Parainfluenza 1</td> <td></td> </tr> </table>	Bacterial	Viral			<input type="checkbox"/> Bordetella pertussis	<input type="checkbox"/> Adenovirus	<input type="checkbox"/> Epstein-Barr virus (EBV)	<input type="checkbox"/> Parainfluenza 2	<input type="checkbox"/> Chlamydia pneumoniae	<input type="checkbox"/> Bocavirus	<input type="checkbox"/> Human herpesvirus 6 (HHV-6)	<input type="checkbox"/> Parainfluenza 3	<input type="checkbox"/> Haemophilus influenzae	<input type="checkbox"/> Coronavirus 229E	<input type="checkbox"/> Human metapneumovirus	<input type="checkbox"/> Parainfluenza 4	<input type="checkbox"/> Klebsiella pneumoniae	<input type="checkbox"/> Coronavirus HKU1	<input type="checkbox"/> Influenza A (Pan)	<input type="checkbox"/> Respiratory Syncytial Virus A	<input type="checkbox"/> Legionella pneumophila	<input type="checkbox"/> Coronavirus NL63	<input type="checkbox"/> Influenza A/H1-2009	<input type="checkbox"/> Respiratory Syncytial Virus B	<input type="checkbox"/> Mycoplasma pneumoniae	<input type="checkbox"/> Coronavirus OC43	<input type="checkbox"/> Influenza A/H3	<input type="checkbox"/> Rhinovirus	<input type="checkbox"/> Streptococcus aureus	<input type="checkbox"/> Cytomegalovirus	<input type="checkbox"/> Influenza B	<input type="checkbox"/> Varicella zoster virus (VZV)	<input type="checkbox"/> Streptococcus pneumoniae	<input type="checkbox"/> Enterovirus	<input type="checkbox"/> Parainfluenza 1	
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<input type="checkbox"/> <b>COMBINATION PANEL - COVID19 WITH BASIC RESPIRATORY PROFILE, PCR - PC1001</b>																																					
<input type="checkbox"/> <b>COMBINATION PANEL - COVID19 WITH COMPLETE RESPIRATORY PROFILE, PCR - PC1002</b>																																					

SAMPLE LIST OF DIAGNOSIS CODES	
<p>The ICD-10 codes provided are for informational purposes only. Correct ICD-10 coding is the sole responsibility of the ordering provider.</p>	
<input type="checkbox"/> R06.9 - Abnormal of breathing, Unspecified <input type="checkbox"/> R09.9 - Abnormal Sputum <input type="checkbox"/> J06.9 - Acu. Upper Respiratory Infections of Unspecified Site <input type="checkbox"/> J00 - Acute Nasopharyngitis <input type="checkbox"/> J02.9 - Acute Pharyngitis <input type="checkbox"/> J01.90 - Acute Sinusitis, Unspecified <input type="checkbox"/> J03.90 - Acute Tonsillitis <input type="checkbox"/> J44.9 - Asthma w. chron. obstructive pulmonary disease (COPD) (HCC) <input type="checkbox"/> J40 - Bronchitis, Unspecified <input type="checkbox"/> R68.83 - Chills (without fever) <input type="checkbox"/> R53.82 - Chronic Fatigue, Unspecified <input type="checkbox"/> J44.9 - COPD <input type="checkbox"/> R5.00 - Cough <input type="checkbox"/> R06.00 - Dyspnea, Unspecified <input type="checkbox"/> J43.2 - Emphysema, Centriobular <input type="checkbox"/> J43.9 - Emphysema, Unspecified <input type="checkbox"/> R50.9 - Fever, Unspecified <input type="checkbox"/> R51 - Headache <input type="checkbox"/> R07.82 - Intercostal chest pain <input type="checkbox"/> R07.81 - Pleurodynia <input type="checkbox"/> R91.1 - Pulmonary Nodule, Solitary <input type="checkbox"/> R06.02 - Shortness of Breath <input type="checkbox"/> J31.0 - Unspecified Rhinitis <input type="checkbox"/> J32.9 - Unspecified Sinusitis, Chronic <input type="checkbox"/> R06.01 - Wheezing <input type="checkbox"/> Z20.828 - Contact with and (suspected) exposure to other viral communicable diseases	

ADDITIONAL TEST/PROFILES

SEND COPY OF REPORT TO	
Physician	Fax