Biocept
Completing the Answer™

COVID-19
Test Requisition

All highlighted areas are mandatory

☐ **Repeat Patient**

STEP 1

CLIENT INFORMATION

Account Number

Ordering Physician

NPI #

PATIENT INFORMATION

Last Name | First Name | MI

Address

City | State | Zip

DOB (mm/dd/yyyy) | ☐ M ☐ F ☐ Undeclared | Patient Phone #

Race ___ (use abbreviations listed)
American Indian/Alaska Native **(AI)**, Asian **(A)**, Black **(B)**, Hawaiian/Pacific Islander **(PI)**, White **(W)**, Other **(O)**, Undeclared **(UD)**, or Unknown **(U)**

Ethnicity ___ (use abbreviations listed)
Hispanic **(H)**, not-Hispanic **(N)**, Undeclared **(UD)**, or Unknown **(U)**

Patient ID # _____
Indicate number listed above: ☐ MRN ☐ Acct# ☐ Employee ID

STEP 2

BILLING INFORMATION

Patient has insurance for this test ☐ Yes (e.g., private insurance, managed care, Medicare, Medicaid, CHAMPUS, TriCare, RailRoad, etc.) ☐ No

Bill to ☐ Insurance/Medicare ☐ Patient ☐ Client

Please Attach the Following: ☐ Insurance Card Copy (Front/Back) or ☐ Copy of Face Sheet ☐ Already on file

Patient type
☐ Inpatient
☐ Outpatient
☐ Non-Hospital Patient

STEP 3

TEST MENU

☐ **COVID-19** - CPT Code U0003

STEP 4

CLINICAL DATA

Collection Date _____(mm/dd/yyyy) Collection Time _____ ☐ am ☐ pm

Specimen Type ☐ OP ☐ NP ☐ Other _____ Diagnosis _____

ICD-10 Code (s)
☐ Z11.59, Encounter for screening for other viral diseases
☐ Z20.828, Contact with and (suspected) exposure to other viral communicable diseases
☐ Other _____

SAMPLE COLLECTION

Use the following for sample collection—oropharyngeal (OP) swab or nasopharyngeal (NP) swab in universal transport medium.

TEST DESCRIPTION

TaqPath™ COVID-19 real-time reverse transcription polymerase chain reaction (RT-PCR) test intended for the qualitative detection of nucleic acid from SARS-CoV-2. This test is intended to be performed on respiratory specimens collected from individuals who meet the Centers for Diseases Control and Prevention (CDC) clinical and/or epidemiological criteria for COVID-19 testing. For details visit https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html.

STEP 5

REQUIRED SIGNATURE:

***By signing below, you represent, with respect to the above-requested test, that (i) this signator below is authorized to prescribe the test or is signing this form at the express direction of someone authorized to prescribe the test; (ii) the test is medically necessary for the care/treatment of the patient; (iii) all necessary government, third party payor, and patient consents and approvals have been obtained to request Biocept to perform the test and to provide Biocept with all necessary information; and (iv) all information provided in this form is accurate and correct; (v) should the test be denied payment by the patient's third party payor, you will be financially responsible for the costs of such test; and (v) should this form conflict with any terms or conditions of any agreement between the parties, this form shall control. You further authorize, approve and consent that any extra patient specimen not needed for clinical testing may be used for internal testing validation in an de-identified manner.

Authorized Signature*** _____ Date _____ (mm/dd/yyyy)

For Biocept Use Only

# of Tubes _____ Tube Type _____

mL Rec'd. 1_____ 2 _____ 3 _____ 4 _____

Expiration Date_____ Lot # _____

Received (initials, date) _____

Comments _____

Biocept, Inc.
9955 Mesa Rim Road, San Diego, CA 92121
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www.biocept.com

LIT 2427.03

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Test Requisition Checklist

1. Client Information

❑ Must indicate Ordering Physician

Patient Information

❑ Provide patient name, complete address and phone number
❑ Provide date of birth and gender
❑ Provide race, ethnicity and patient ID #

2. Billing Information

❑ Must select ONE option
Bill to:
- Insurance
  - If Yes, you must include front and back of requisition or facesheet.
  - If No, choose one of the following:
- Patient or
- Client

3. Test Menu

❑ Order COVID-19

4. Clinical Data

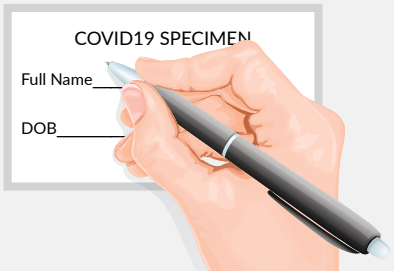
❑ Collection date and time
❑ Specimen type
❑ Diagnosis and ICD10 code

5. Required Signature

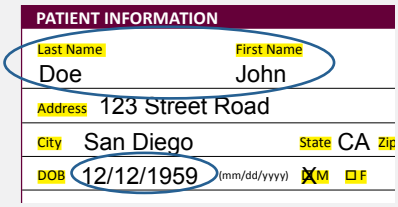
❑ Physician or Authorized Provider must sign requisition

Label Specimen Collection Tube

- MUST include two patient identifiers on the tube, patient FULL name (first and last) AND date of birth
- Only use non-gel or indelible pen to prevent ink bleed on the label



- Patient name and date of birth on the tube must match name and date of birth on test requisition



- Secure lid to ensure sample will not spill in transit
- Do not forcefully tighten the lid

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