Birdrock Laboratories

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Section 1: Patient Information

Email

Name (Last, First, M.I.)

Street Address | City | State | Zip

Date of Birth (MM/DD/YYYY) | Gender ☐ Female ☐ Male | Phone

Payment ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Employer Pay ☐ No Insurance ☐ Self-Pay ☐ Client Bill

Insurance Name: _____

Member ID: _____ Group No. _____

ATTACH A COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE INFO. IF AVAILABLE

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race ☐ American Indian or Alaska Native ☐ Black or African American ☐Native Hawaiian or other Pacific Islander ☐ White ☐ Asian ☐Other

☐ Section 2: Ordering Physician

Rajeev Kumar, MD	Rankin School District #98	1578511176
Physician Name	Practice Name	NPI

Section 3: Specimen Information

Collection Type

☐ Saliva ☐ Anterior Nares

Date Collected (MM/DD/YYYY) | Time Collected (HH:MM) ☐ AM ☐ PM | ☐ Nasopharyngeal swab | _____ Collector's Initials

Section 4: Test Requested

☐ SARS-CoV-2 (PCR)
☐ SARS-CoV-2 (Antigen)

ICD-10 CODES

The following are provided for the physician's convenience only.
Please Check all the codes that apply

☐ R50.9 Fever, unspecified
☐ R05 Cough
☐ R06.02 Shortness of Breath
☐ Z11.59 Encounter for screening for other viral diseases
☐ Z20.828 Contact with and (suspected (exposure to other viral communicable diseases
☐ Other: _____

Section 5: Patient Consent

I request and authorize a CLIA-certified laboratory to perform the above designated test(s) on the sample provided by me. My signature below constitutes my acknowledgment that I have been informed of the benefits and limitations of this test which have been explained to my satisfaction by a qualified health professional.

Assignment of Benefits: If applicable, I hereby authorize H&M Molecular Diagnostics, LLC to bill my insurance company and receive payment from them on my behalf.

Appeal Authorization: If applicable, in the event of an underpayment or denial by my insurance carrier, I hereby authorize H&M Molecular Diagnostics, LLC or their designee, to Appeal my health plan on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. * This authorization shall remain valid until the charges for the orders on this form are paid in full.

Donor Signature: I certify that I provided my specimen to the collector: that I have not adulterated it in any manner: each specimen used was sealed in my presence; and that the information provided on this form and on the label affixed to each specimen is correct. I authorize the release of the results to the ordering clinician, authorized client/representative, or medical review officer. I authorize H&M Molecular Diagnostics to release any information required for billing purposes. Acknowledge that H&M Molecular Diagnostics be an out of network provider with my insurer. I also agree that in a case where my insurance provider send payment directly to me, I will endorse the insurance check and forward it to H&M Molecular Diagnostics within 30 days. I understand that the failure to do so may result in my account being forwarded to collection and reported to a credit bureau.

* H&M Molecular Diagnostics, LLC and/or designee may perform this appeal on my behalf but is not obligated to do so.

X_____
Patient Signature | Date

Section 6: Parent Consent. *Required if the patient is 12 years of age or under.*

X_____
Parent Signature | Date

Section 6: Authorized Healthcare Provider Acknowledgment

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity

X_____
Provider Signature | Date