Facility Name and Address:

Ordering Physician Name:

Ordering Physician NPI:

PATIENT CONSENT STATEMENT

I authorize the release of the results to the ordering clinician, authorized client/representative, or medical review officer. I authorize Priority Toxicology Laboratories to release any information for billing purposes. As the beneficiary of my health insurance, I hereby assign to Priority Toxicology Laboratories my right to coverage and payment for the testing received by me and performed on my behalf by Priority Toxicology Laboratories. I also agree that in a case where my insurance provider sends payment directly to me I will endorse the insurance check and forward to Priority Toxicology Laboratories within 30 days.

Patient Signature: ______________________________ DATE: ______________

PATIENT INFORMATION

Last Name: ______________ First Name: ______________

Middle Name: ______________ ☐*F* ☐*M* DOB: ___/___/___ Phone:(___) ______________

Address: ______________________________ SSN: | | | |-| | |-| | | | |

City: ______________ State: ______ Zip: ______________

Email Address: ______________________________

BILLING INFORMATION

☐Patient ☐Medicare ☐Insurance ☐Client ☐Medicaid

RELATIONSHIP

☐ Self ☐ Spouse ☐ Child Other ______________

Insurance Company ______________ Member # ______________

☒ COVID-19

Diagnosis Codes:
*****must select one******

☐ Z20.822 - Contact with and (suspected) exposure to COVID-19
☐ Z11.52 - Encounter for screening for COVID-19
☐ Z86.16 - Personal history of COVID-19

Medical Professional Statement

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services,

I have obtained this patient's informed consent to undergo any COVID testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

ORDERING PHYSCIAN SIGNATURE ______________________________ **DATE** ______________

Priority Toxicology Laboratories
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CLIA#11D2108401
Medical Director: Lisa Bates-Dubrow Ph.D.