GENEX LABORATORIES

PNEUMONIA PANEL REQUEST FORM

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

DATE OF BIRTH | GENDER ☐ MALE ☐ FEMALE | PREFERRED CONTACT PHONE NUMBER

PATIENT INSURANCE INFORMATION-*PLEASE ATTACH INSURANCE CARD COPY*

PRIMARY INSURANCE CARRIER | PRIMARY INSURANCE POLICY/ID NO. | PRIMARY INSURANCE GROUP NO.

SECONDARY INSURANCE NAME (if any) | SECONDARY INSURANCE POLICY/ID NO. | SECONDARY INSURANCE GROUP NO.

TEST OPTIONS:

☐ LOWER RESPIRATORY

ICD-10 CODE(S):

- ☐ R05.3 Chronic Cough
- ☐ R06.02 Wheezing
- ☐ R50.9 Fever, unspecified
- ☐ J12.9 Viral Pneumonia, unspecified
- ☐ J20.9 Acute Bronchitis, unspecified
- ☐ J449 COPD
- ☐ E11.43 Type 2 Diabetes mellitus with diabetic autonomic (poly) neuropathy
- ☐ D70.9 Neutropenia, unspecified
- ☐
- ☐

PRACTICE/CLINIC INFORMATION

PRACTICE/CLINIC NAME | PRACTICE/CLINIC PHONE #

PRACTICE/CLINIC ADDRESS

CLINICIAN SIGNATURE

ORDERING CLINICIAN ACKNOWLEDGEMENT: *I acknowledge that the tests ordered are medically necessary, and if ordered for the purpose of screening or the likelihood of payment denial has been explained to the patient, prior to obtaining the laboratory specimen, who has signed the Advanced Beneficiary Notice and agreed to be financially responsible for payment of denied tests.*

PATIENT CONSENT

INFORMED CONSENT OF TEST INFORMATION*: I consent to having the aforementioned analysis performed and the results of the analysis made available to my physician. This signed test request form authorizes Genex Laboratories to perform the test and disclose the results to my medical practitioner. No tests other than those requested above will be performed. I authorize Genex Laboratories to retain this specimen for future testing as requested.*

PATIENT NAME (Please Print) | **PATIENT SIGNATURE** | **DATE**

COLLECTION INFORMATION

DATE COLLECTED: | **TIME COLLECTED (AM/PM)** | **COLLECTED BY (NAME & SIGNATURE)**

GENEX LABORATORIES
1301 N SAN FERNANDO BLVD.
BURBANK, CA 91504

FOR LAB USE ONLY →

RECEIVED IN LAB		
DATE	**TIME**	**INITIAL**