Clinic/Facility Name: _____

Account #: _____

Provider(s): MAKO ON SITE

Physician Name: _____ NPI #: _____

MAKO MEDICAL
1 Industry Drive, Henderson, NC 27537
Phone: (252) 572-2795
Fax: (252) 572-4595
CLIA ID: 34D2141858

Clinical Laboratory Improvement Amendments

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Information highlighted in RED is required. Attach a copy of patient ID & insurance card.

COVID-19 REQUISITION

1. Patient Demographics

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City/State/Zipcode: _____

Phone #: _____ Email Address: _____

Guardian: ☐ Parent ☐ Guardian ☐ Other (In Loco Parentis) Phone #: _____

Last Name: _____ First Name: _____ MI: _____

Sex: ☐ Male ☐ Female

Pregnant: ☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Multi-Race
- ☐ Native Hawaiian of Other Pacific Islande
- ☐ Unknown
- ☐ White
- ☐ Other
- ☐ Refused to Answer

2. Specimen Collection Information

Collector Name: _____ Collection Date: ___/___/___

Collection Time: _____ Collection Procedure: ☑ Nasal ☐ Oral ☐ Nasopharyngeal

Do not order non-medically necessary tests

3. Test Selection and Diagnosis Code Selection

TEST TYPE: ☑ PCR ☐ ANTIBODY ☐ ANTIGEN

☑ **720100 COVID-19 SARS-COV-2 by RT-PCR U0003**

COVID-19 DX CODES

- ☐ **R05** Cough
- ☐ **R50.9** Fever, unspecifie
- ☐ **Z03.818** Encounter for observation for suspected exposure to other biological agents ruled out
  For cases where there is a concern for possible COVID-19 exposure
- ☐ **Z20.828** Contact with and (suspected) exposure to other viral communicable diseases.
  Only to be used if actual exposure with someone confirmed to have COVID-19
- ☐ **R06.02** Shortness of Breath
- ☐ **Z11.59** Encounter for screening for other viral diseases

Consent/Insurance Release: I, the undersigned, understand and grant permission to Mako Medical Laboratories, LLC to bill my insurance for laboratory services provided. I understand that services provided may not be covered by my insurance. I further understand that I may be responsible for co-pays, deductibles, and any amount not covered by my insurer. By signing below, I acknowledge that payment may be made on my behalf to Mako Medical Laboratories, LLC. I hereby authorize the ordering physician and/or clinic to disclose any personal or medical information that may be needed to process claims related to services rendered by Mako Medical Laboratories, LLC and its affiliates including information that pertains to my participation in substance abuse treatment. I understand that my records may be protected under 42 CFR Part 2, under which I may revoke my consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires six (6) months after the date of program discharge.

Patient Signature: N/A- IMPLIED CONSENT-MOBILE LOCATION ☐ **Patient Signature On File**

Provider Signature: COMMONWEALTH OF VIRGINIA