77 Upper Rock, Floor 4
Rockville, MD 20850
CLIA # 21D2130541
Todd Myers, PhD, Lab Director

8515 Fannin St., Ste 110
Houston, TX 20850
CLIA # 45D2181291
Todd Myers, PhD, Lab Director

CIRRUSDX

Lab Use Only

Respiratory Test Requisition Form

Patient & Specimen Information	Practice/Facility Information
Patient Name: ***Address:*** ***Phone Number:***	***Practice Name/Address:*** ***Phone Number:***
DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male***	***Ordering Physician (Name/NPI):***
Medical Record #:	
Date of Collection: ***Collected by:***	***Patient Race/Ethnicity:*** ☐African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Hispanic (non-Latino)☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Prefer not to disclose ☐ Other: _____ ****if no race/ethnicity is selected it will automatically be entered as "prefer not to disclose"***
Specimen type (check one): ☐Nasopharyngeal ☐ Nasal ☐ Oropharyngeal ☐ Other: _____ ****if no specimen type is selected, it will be entered as unknown***	

Test Requested
☐ SARS-CoV-2 Molecular RT-PCR Test
☐ Influenza A, Influenza B and RSV Molecular RT-PCR Test ONLY (itemized list of tests in panel ☐ Influenza A, ☐ Influenza B, ☐ RSV)
☐ Influenza A, Influenza B, RSV **AND** SARS-CoV-2 Molecular RT-PCR Test

ICD-10 Diagnosis Codes: Please check all that apply:		
COVID-19 / SARS CoV-2	Influenza	RSV
☐ Z03.818 Suspected exposure, other biological ruled out	☐ J80 Acute Respiratory Distress Syndrome	☐ J10.89 Influenza due to other identified influenza virus with other manifestations
☐ Z20.828 Exposure from someone confirmed COVID-19	☐ J09.X1 Influenza due to identified novel influenza A virus with pneumonia	☐ J11.83 Influenza due to unidentified influenza virus with otitis media
☐ R50.9 Fever Unspecified	☐ J10.08 Influenza due to other identified influenza virus with other specified pneumonia	☐ G44.1 Vascular headache, not elsewhere classified
☐ R06.02 Shortness of Breath	☐ J10.83 Influenza due to other identified influenza virus with otitis media	☐ J12.1 Respiratory syncytial virus pneumonia
☐ J12.89 Other coronavirus	☐ J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations	☐ R05 Cough
☐ J20.8 Acute bronchitis	☐ J10.1 Influenza due to other identified influenza virus with other respiratory manifestations	

AUTHORIZATION: I understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance, litigation or third party liability. I am authorizing CirrusDx to submit claims and acknowledging that payment(s) of authorized insurance benefits or attorney settlements, including but not limited to Medicaid, Medicare, other benefits or payments shall be made on my behalf to CirrusDx. If my current policy prohibits direct payments to CirrusDx, I agree to receive the funds and relinquish them to CirrusDx as payment towards charges for services rendered.

Patient Signature / Authorization: _____ **Date:**____/____/_____

☐ Check here if: "I do NOT consent to CirrusDx retaining the remnants (left over specimen) after the requested testing. The left over specimens are typically used for Quality Control, assay improvement, or other purposes mainly to further improve testing by CirrusDx. My specimen is to be processed solely for the requested test."

Physician/Authorized Signature: _____ Date: _____

Billing Information - *Attach a copy of the insurance card and PATIENT demographic sheet*	
☐Client Bill ☐Medicare ☐Medicaid ☐Commercial	Insurance Plan:_____ Policy #:_____ Referral #:_____ Patient relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy Holder Name:_____ DOB:____/_____/_____

77 Upper Rock, Floor 4
Rockville, MD 20850
CLIA # 21D2130541
Todd Myers, PhD, Lab Director

8515 Fannin St., Ste 110
Houston, TX 20850
CLIA # 45D2181291
Todd Myers, PhD, Lab Director

CIRRUSDX

Lab Use Only

Respiratory Test Requisition Form

Patient & Specimen Information	Practice/Facility Information
Patient Name: ***Address:*** ***Phone Number:***	***Practice Name/Address:*** ***Phone Number:***
DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male***	***Ordering Physician (Name/NPI):***
Medical Record #:	
Date of Collection: ***Collected by:***	***Patient Race/Ethnicity:*** ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino
Spe ☐ O ****if n***	

Practice/Facility Information

Practice Name/Address:

Phone Number:

Ordering Physician (Name/NPI):

☐ S		
☐ I		
☐ I		

☐ Z0 ruled		
☐ Z2 COVI		
☐ R5		
☐ R06.02 Shortness of Breath	virus with otitis media	☐ J12.1 Respiratory syncytial virus pneumonia
☐ J12.89 Other coronavirus	☐ J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations	☐ R05 Cough
☐ J20.8 Acute bronchitis	☐ J10.1 Influenza due to other identified influenza virus with other respiratory manifestations	

AUTHORIZATION: I understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance, litigation or third party liability. I am authorizing CirrusDx to submit claims and acknowledging that payment(s) of authorized insurance benefits or attorney settlements, including but not limited to Medicaid, Medicare, other benefits or payments shall be made on my behalf to CirrusDx. If my current policy prohibits direct payments to CirrusDx, I agree to receive the funds and relinquish them to CirrusDx as payment towards charges for services rendered.

Patient Signature / Authorization: _____ **Date:**____/____/_____

☐ Check here if: "I do NOT consent to CirrusDx retaining the remnants (left over specimen) after the requested testing. The left over specimens are typically used for Quality Control, assay improvement, or other purposes mainly to further improve testing by CirrusDx. My specimen is to be processed solely for the requested test."

Physician/Authorized Signature: _____ Date: _____

Billing Information - *Attach a copy of the insurance card and PATIENT demographic sheet*	
☐Client Bill ☐Medicare ☐Medicaid ☐Commercial	Insurance Plan:_____ Policy #:_____ Referral #:_____ Patient relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy Holder Name:_____ DOB:____/_____/_____

77 Upper Rock, Floor 4
Rockville, MD 20850
CLIA # 21D2130541
Todd Myers, PhD, Lab Director

8515 Fannin St., Ste 110
Houston, TX 20850
CLIA # 45D2181291
Todd Myers, PhD, Lab Director

CIRRUSDX

Lab Use Only

Respiratory Test Requisition Form

Patient & Specimen Information	Practice/Facility Information
Patient Name: ***Address:*** ***Phone Number:***	***Practice Name/Address:*** ***Phone Number:***
DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male***	***Ordering Physician (Name/NPI):***
Medical Record #:	
Date of Collection: ***Collected by:***	***Patient Race/Ethnicity:*** ☐African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Hispanic (non-Latino)☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Prefer not to disclose ☐ Other: _____ ****if no race/ethnicity is selected it will automatically be entered as "prefer not to disclose"***
Specimen type (check one): ☐Nasopharyngeal ☐ Nasal ☐ Oropharyngeal ☐ Other: _____ ****if no specimen type is selected, it will be entered as unknown***	

Patient & Specimen Information

Patient Name:
Address:

Phone Number:

DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male***

Medical Record #:

Date of Collection:
Collected by:

Specimen type (check one): ☐Nasopharyngeal ☐ Nasal
☐ Oropharyngeal ☐ Other: _____
****if no specimen type is selected, it will be entered as unknown***

☐Medicaid
☐Commercial

Patient relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holder Name:_____ DOB:____/_____/_____

77 Upper Rock, Floor 4
Rockville, MD 20850
CLIA # 21D2130541
Todd Myers, PhD, Lab Director

8515 Fannin St., Ste 110
Houston, TX 20850
CLIA # 45D2181291
Todd Myers, PhD, Lab Director

CIRRUSDX

Lab Use Only

Respiratory Test Requisition Form

Patient & Specimen Information	Practice/Facility Information
Patient Name: ***Address:*** ***Phone Number:***	***Practice Name/Address:*** ***Phone Number:***
DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male***	***Ordering Physician (Name/NPI):***
Medical Record #:	

Test Requested

☐ SARS-CoV-2 Molecular RT-PCR Test

☐ Influenza A, Influenza B and RSV Molecular RT-PCR Test ONLY (itemized list of tests in panel ☐ Influenza A, ☐ Influenza B, ☐ RSV)

☐ Influenza A, Influenza B, RSV **AND** SARS-CoV-2 Molecular RT-PCR Test

"prefer not to disclose"

Test Requested

☐ SARS-CoV-2 Molecular RT-PCR Test

☐ Influenza A, Influenza B and RSV Molecular RT-PCR Test ONLY (itemized list of tests in panel ☐ Influenza A, ☐ Influenza B, ☐ RSV)

☐ Influenza A, Influenza B, RSV **AND** SARS-CoV-2 Molecular RT-PCR Test

ICD-10 Diagnosis Codes: Please check all that apply:		
COVID-19 / SARS CoV-2	Influenza	RSV
☐ Z03.818 Suspected exposure, other biological ruled out	☐ J80 Acute Respiratory Distress Syndrome	☐ J10.89 Influenza due to other identified influenza virus with other manifestations
☐ Z20.828 Exposure from someone confirmed COVID-19	☐ J09.X1 Influenza due to identified novel influenza A virus with pneumonia	☐ J11.83 Influenza due to unidentified influenza virus with otitis media
☐ R50.9 Fever Unspecified	☐ J10.08 Influenza due to other identified influenza virus with other specified pneumonia	☐ G44.1 Vascular headache, not elsewhere classified
☐ R06.02 Shortness of Breath	☐ J10.83 Influenza due to other identified influenza virus with otitis media	☐ J12.1 Respiratory syncytial virus pneumonia
☐ J12.89 Other coronavirus	☐ J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations	☐ R05 Cough
☐ J20.8 Acute bronchitis	☐ J10.1 Influenza due to other identified influenza virus with other respiratory manifestations	

AUTHORIZATION: I understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance, litigation or third party liability. I am authorizing CirrusDx to submit claims and acknowledging that payment(s) of authorized insurance benefits or attorney settlements, including but not limited to Medicaid, Medicare, other benefits or payments shall be made on my behalf to CirrusDx. If my current policy prohibits direct payments to CirrusDx, I agree to receive the funds and relinquish them to CirrusDx as payment towards charges for services rendered.

Patient Signature / Authorization: _____ **Date:**____/____/_____

☐ Check here if: "I do NOT consent to CirrusDx retaining the remnants (left over specimen) after the requested testing. The left over specimens are typically used for Quality Control, assay improvement, or other purposes mainly to further improve testing by CirrusDx. My specimen is to be processed solely for the requested test."

Physician/Authorized Signature: _____ Date: _____

Billing Information - *Attach a copy of the insurance card and PATIENT demographic sheet*	
☐Client Bill ☐Medicare ☐Medicaid ☐Commercial	Insurance Plan:_____ Policy #:_____ Referral #:_____ Patient relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy Holder Name:_____ DOB:____/_____/_____

77 Upper Rock, Floor 4
Rockville, MD 20850
CLIA # 21D2130541
Todd Myers, PhD, Lab Director

8515 Fannin St., Ste 110
Houston, TX 20850
CLIA # 45D2181291
Todd Myers, PhD, Lab Director

CIRRUSDX

Lab Use Only

Respiratory Test Requisition Form

Patient & Specimen Information	Practice/Facility Information
Patient Name: ***Address:*** ***Phone Number:***	***Practice Name/Address:*** ***Phone Number:***
DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male*** ***Medical Record #:***	***Ordering Physician (Name/NPI):***
Date of Collection: ***Collected by:*** ***Specimen type (check one):*** ☐Nasopharyngeal ☐ Nasal ☐ Oropharyngeal ☐ Other: _____ ****if no specimen type is selected, it will be entered as unknown***	***Patient Race/Ethnicity:*** ☐African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Hispanic (non-Latino)☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Prefer not to disclose ☐ Other: _____ ****if no race/ethnicity is selected it will automatically be entered as "prefer not to disclose"***

Test Requested
☐ SARS-CoV-2 Molecular RT-PCR Test
☐ Influenza A, Influenza B and RSV Molecular RT-PCR Test ONLY (itemized list of tests in panel ☐ Influenza A, ☐ Influenza B, ☐ RSV)
☐ Influenza A, Influenza B, RSV **AND** SARS-CoV-2 Molecular RT-PCR Test

ICD-10 Diagnosis Codes: Please check all that apply:

COVID-19 / SARS CoV-2	Influenza	RSV
☐ Z03.818 Suspected exposure, other biological ruled out	☐ J80 Acute Respiratory Distress Syndrome	☐ J10.89 Influenza due to other identified influenza virus with other manifestations
☐ Z20.828 Exposure from someone confirmed COVID-19	☐ J09.X1 Influenza due to identified novel influenza A virus with pneumonia	☐ J11.83 Influenza due to unidentified influenza virus with otitis media
☐ R50.9 Fever Unspecified	☐ J10.08 Influenza due to other identified influenza virus with other specified pneumonia	☐ G44.1 Vascular headache, not elsewhere classified
☐ R06.02 Shortness of Breath	☐ J10.83 Influenza due to other identified influenza virus with otitis media	☐ J12.1 Respiratory syncytial virus pneumonia
☐ J12.89 Other coronavirus	☐ J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations	☐ R05 Cough
☐ J20.8 Acute bronchitis	☐ J10.1 Influenza due to other identified influenza virus with other respiratory manifestations	

AUTHORIZATION: I understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance, litigation or third party liability. I am authorizing CirrusDx to submit claims and acknowledging that payment(s) of authorized insurance benefits or attorney settlements, including but not limited to Medicaid

ICD-10 Diagnosis Codes: Please check all that apply:

COVID-19 / SARS CoV-2	Influenza	RSV
☐ Z03.818 Suspected exposure, other biological ruled out	☐ J80 Acute Respiratory Distress Syndrome	☐ J10.89 Influenza due to other identified influenza virus with other manifestations
☐ Z20.828 Exposure from someone confirmed COVID-19	☐ J09.X1 Influenza due to identified novel influenza A virus with pneumonia	☐ J11.83 Influenza due to unidentified influenza virus with otitis media
☐ R50.9 Fever Unspecified	☐ J10.08 Influenza due to other identified influenza virus with other specified pneumonia	☐ G44.1 Vascular headache, not elsewhere classified
☐ R06.02 Shortness of Breath	☐ J10.83 Influenza due to other identified influenza virus with otitis media	☐ J12.1 Respiratory syncytial virus pneumonia
☐ J12.89 Other coronavirus	☐ J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations	☐ R05 Cough
☐ J20.8 Acute bronchitis	☐ J10.1 Influenza due to other identified influenza virus with other respiratory manifestations	

☐Commercial	Policy Holder Name:_____ DOB:____/_____/_____

77 Upper Rock, Floor 4
Rockville, MD 20850
CLIA # 21D2130541
Todd Myers, PhD, Lab Director

8515 Fannin St., Ste 110
Houston, TX 20850
CLIA # 45D2181291
Todd Myers, PhD, Lab Director

CIRRUSDX

Lab Use Only

Respiratory Test Requisition Form

Patient & Specimen Information	Practice/Facility Information
Patient Name: ***Address:*** ***Phone Number:***	***Practice Name/Address:*** ***Phone Number:***
DOB: ***Sex:*** ☐ ***Female*** ☐ ***Male*** ***Medical Record #:***	***Ordering Physician (Name/NPI):***
Date of Collection: ***Collected by:*** ***Specimen type (check one):*** ☐Nasopharyngeal ☐ Nasal ☐ Oropharyngeal ☐ Other: _____ ****if no specimen type is selected, it will be entered as unknown***	***Patient Race/Ethnicity:*** ☐African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Hispanic (non-Latino)☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Prefer not to disclose ☐ Other: _____ ****if no race/ethnicity is selected it will automatically be entered as "prefer not to disclose"***

Test Requested
☐ SARS-CoV-2 Molecular RT-PCR Test
☐ Influenza A, Influenza B and RSV Molecular RT-PCR Test ONLY (itemized list of tests in panel ☐ Influenza A, ☐ Influenza B, ☐ RSV)
☐ Influenza A, Influenza B, RSV **AND** SARS-CoV-2 Molecular RT-PCR Test

ICD-10 Diagnosis Codes: Please check all that apply:		
COVID-19 / SARS CoV-2	Influenza	RSV
☐ Z03.818 Suspected exposure, other biological ruled out	☐ J80 Acute Respiratory Distress Syndrome	☐ J10.89 Influenza due to other identified influenza virus with other manifestations
☐ Z20.828 Exposure from someone confirmed COVID-19	☐ J09.X1 Influenza due to identified novel influenza A virus with pneumonia	☐ J11.83 Influenza due to unidentified influenza virus with otitis media
☐ R50.9 Fever Unspecified	☐ J10.08 Influenza due to other identified influenza virus with other specified pneumonia	☐ G44.1 Vascular headache, not elsewhere classified
☐ R06.02 Shortness of Breath	☐ J10.83 Influenza due to other identified influenza virus with otitis media	☐ J12.1 Respiratory syncytial virus pneumonia
☐ J12.89 Other coronavirus	☐ J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations	☐ R05 Cough

Billing Information - *Attach a copy of the insurance card and PATIENT demographic sheet*

☐Client Bill
☐Medicare
☐Medicaid
☐Commercial

Insurance Plan:_____

Policy #:_____ Referral #:_____

Patient relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Name:_____ DOB:____/_____/_____

processed solely for the requested test."

Physician/Authorized Signature: _____ Date: _____

Billing Information - *Attach a copy of the insurance card and PATIENT demographic sheet*

☐Client Bill
☐Medicare
☐Medicaid
☐Commercial

Insurance Plan:_____

Policy #:_____ Referral #:_____

Patient relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Name:_____ DOB:____/_____/_____