COVID-19 Neutralizing Antibodies Requisition Form

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Clinic Name	Requesting Physician	Collection Information
______________	______________	date & time collected: ______________ collected by (*print*): ______________

Patient Information

REQUIRED: *Enclose a copy of the front and back of patient's insurance card(s), driver's license, and patient demographic.*

last ______ first ______ middle initial ______ date of birth ______ sex ☐ male ☐ female

address ______ city ______ state ______ zip ______

phone ______ ethnicity ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

Payment Information

☐ Insurance ☐ Medicare ☐ Medicaid ☐ Client Bill ☐ Self pay

Test Requested

☐ **Qualitative** ☐ **Quantitative**

ICD-10 Codes - Select/indicate ICD-10 code(s)

	ICD-10 Code	Description
☐	Z20.822	Contact with and (suspected) exposure to COVID-19
☐	Z20.828	Known exposure to COVID-19
☐	Z03.818	Suspected exposure to COVID-19
☐	Z86.16	Personal history of COVID-19
☐	J12.89	Pneumonia, Other viral pneumonia
☐	B97.29	Pneumonia, Other coronavirus
☐	J20.8	Acute bronchitis due to other specified organisms
☐	J40	Bronchitis
☐	R05	Cough
☐	R06.02	Shortness of breath
☐	J01.80	Other acute sinusitis
☐	J02.8	Acute pharyngitis due to other specified organisms
☐	J12.82	Pneumonia due to COVID-19
☐	J32.8	Other chronic sinusitis
☐	J21.8	Acute bronchiolitis due to other specified organisms
☐	M35.89	Other specified systemic involvement of connective tissue
☐	Z11.52	Encounter for screening for COVID-19
☐	Other (*Please Specify*)	____

Questionnaire

1. Is this your first COVID-19 antibody test? Y/N
   If so, what were your results? ______

2. Have you had COVID-19? Y/N
   If so, when? __ 1-3 months ago
   __4-6 months ago __7 months-1 year ago
   __> than 1 year ago

3. Were you symptomatic as defined by CDC, but NOT tested? Y/N

4. Have you been vaccinated? Y/N
   If so, when and what manufacturer?
   i. Moderna
   1st dose date ____________
   2nd dose date ___________
   ii. Pfizer
   1st dose date ____________
   2nd dose date ___________
   iii. Johnson & Johnson
   Dose date ____________

I agree that no tests other than the specific serological test(s) ordered shall be performed on this biological sample. The sample shall be destroyed within five days after the sample was taken.

I, the undersigned, understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization, I am acknowledging that payment(s) be made on my behalf to Elina Labs for any services provided to me by Elina Labs. I also allow the release of any medical information necessary to process this claim.

I authorize the above ordered laboratory test(s). If no test(s) is selected, Elina Labs will test the quantitative neutralizing antibody.

Patient Signature: ____________________ **Date:** ____________

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Provider Signature: ____________________ **Date:** ____________