26497 Rancho Parkway South
Lake Forest, California 92630
Phone: (949) 207-3315 | Fax: (949) 315-3096
www.inspirediagnostics.com CLIA #: 05D2203452

ACCOUNT INFORMATION	PATIENT INFORMATION
GROUP/PRACTICE NAME	Last Name / First Name
Address	Date of Birth (MM/DD/YY) / Sex ☐ M ☐ F
Address	Address
City / State / ZIP	City / State / ZIP
Phone #: / Fax #:	Phone #: / Email:
	Race: ☐ White ☐ Latino ☐ Asian ☐ African American ☐ American Indian/Alaska Native ☐ Multi-Race ☐Native Hawaiian/Other Pacific Islander ☐ Other
Ordering Physician Steven Kim, MD	Ethnicity: ☐ Hispanic ☐ Non-Hispanic
The ordering physician must sign his/her name and indicate the date the test is ordered. The signature constitutes as a certification, that with respect to tests reimbursed by Medicare, Medicaid, or other third-party payers that the testing is medically necessary, and the results will be used in the management of the patient. X ____________________ Physician Signature Date	I authorize Inspire Diagnostics to release the results of this testing to the treating physician or facility. I have read and understood the ABN provided with this form. X ____________________ If Patient under 18, Parent/Guardain Signature Date X ____________________ Patient Signature Date
	Insured's Name (If different from patient)

SPECIMEN TYPE	
☐ Nasopharyngeal ☐ Oropharyngeal ☐ Nasal ☐ RNA	Primary Insurance Name & Plan / Workers Comp. Carrier
Collection Date:__________Time: AM/PM	Address (Insurance)
Collector Name: ____________________	Policy # / Group/Plan/Book #

TEST REQUESTED

☐	COVID-19 Only (SARS-CoV-2 Molecular Assay)	☐	Respiratory Pathogen Panel w/ COVID-19 Test Influenza AB Streptococcus A
☐	COVID-19 Only (SARS-CoV-2 Antigen Test)		
☐	COVID-19 Only (SARS-CoV-2 Antibody IgM/IgG Test)		

ICD-10 CODES

COVID-19 CODES ARE LISTED BELOW AND MUST BE CHECKED OFF

☐	R05	COUGH
☐	R06.02	SHORTNESS OF BREATH
☐	R50.9	FEVER UNSPECIFIED
☐	Z03.818	SUSPECTED EXPOSURE TO COVID -19
☐	Z20.828	KNOWN EXPOSURE TO COVID-19
☐	OTHER	
☐	OTHER	