Sterling Pathology National Laboratories

Respiratory Pathogen Panel (RPP) Requisition Form

Internal use only

PATIENT DEMOGRAPHICS

Specimen Collection Date (MM/DD/YYYY): _____/_____/_____	**Specimen Collection Time:** _____:_____AM/PM	
Patient Last Name	**Patient First Name**	**Date of Birth**
Patient Street Address	City	State Zip Code
Patient Phone #	Gender ☐ Male ☐ Female	Race / Ethnicity
Office Contact	**Ordering Physician**	**Physician NPI#**

RESPIRATORY PATHOGEN PANEL (RPP)

☐ **SARS-CoV-2 PCR** (Only)

☐ **Flu+ Panel:**
- Influenza A
  - Subtype H1
  - Subtype H1 2009pdm
  - Subtype H3
- Influenza B
- Respiratory Syncytial Virus A and B
- SARS-CoV-2

☐ **Reflex Complete RPP**

☐ **Complete Respiratory Pathogen Panel (RPP): (Check all that apply)**

Viruses:
- ☐ Parainfluenza 1
- ☐ Parainfluenza 2
- ☐ Parainfluenza 3
- ☐ Parainfluenza 4
- ☐ Human Metapneumovirus A and B
- ☐ Rhinovirus/Enterovirus
- ☐ Coronavirus (229E, OC43, HKU1, and NL63)
- ☐ Adenovirus

Bacteria:
- ☐ *Mycoplasma pneumoniae*
- ☐ *Chlamydia pneumoniae*
- ☐ *Bordetella pertussis*

BILLING INFORMATION

Payment and Insurance Information: **Please include photocopy of both sides of insurance card or face sheet.**

Name of Person Insured	Relationship to Insured	DOB of Insured

MEDICAL NECESSITY (Please check all that apply) :

☐ Screening for pathogen exposure

☐ Current Symptoms: _____

RPP DIAGNOSIS ICD-10 CODES

- ☐ **R05 Cough**
- ☐ **R06.02 Shortness of Breath**
- ☐ **R50.9 Fever, Unspecified**
- ☐ **J01.90 Acute Sinusitis, Unspecified**
- ☐ **J02.9 Acute Pharyngitis, Unspecified**
- ☐ **J06.9 Acute Upper Respiratory Infection, Unspecified**
- ☐ **J18.9 Pneumonia, Unspecified organism**
- ☐ **J20.9 Acute Bronchitis, Unspecified**
- ☐ **J32.9 Chronic Sinusitis, Unspecified**

Additional ICD-10 codes:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

I request and authorize Sterling Pathology to perform the designated test(s) on the sample provided by me. My signature below constitutes my acknowledgment that I have been informed of the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional. **Assignment of Benefits**: I hereby authorize Sterling Pathology or its affiliate to bill my insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with its collection. I hereby authorize my insurance company to pay the company directly for services rendered **Appeal Authorization**: In the event of an underpayment or denial by my insurance carrier, I hereby authorize the company or their designee, to appeal my health plan on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full. **Donor Signature**: I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen used was sealed in my presence; and that the information provided on this form and on the label affixed to each specimen is correct. I authorize the release of the results to the ordering clinician, authorized client/representative, or prescribing/attending physician. I authorize Sterling Pathology or its affiliates to release any information required for billing purposes. I acknowledge Sterling Pathology or its affiliates may be an out of network provider with my insurer. I also agree that in a case where my insurance provider sends payment directly to me, I will endorse the insurance check and forward to Sterling Pathology within 30 days.

Print Patient Name	Patient Signature	Date

Physician Certification: I hereby request and authorize reference/testing lab to utilize this information to perform RPP testing for the indicated patient. I certify that I have explained RPP testing to the patient indicated in this requisition form. I also certify that I will only use and disclose test results as permitted by law.

Physician Authorizing Name	Physician Authorizing Signature	Date