

Patient Name _____ DOB _____ 502750 UA	Patient Name _____ DOB _____ 502750	Patient Name _____ DOB _____ 502750
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502750

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 CLIA #45D2287536



Customer Information

MOLECULAR DIAGNOSTICS via PCR

Last Name: _____ First Name: _____ DOB: ____/____/____
(Must be 18 years or older)
 Date Collected: ____/____/____ Time Collected: ____:____ AM / PM Biological Sex: M F
 Ordering Provider: _____ Attach patient demographics w/insurance card Uninsured Patient

Diagnosis Code(s):* _____

- Black/African-American Hispanic/Latino/Spanish Origin Asian American Indian/Alaskan Native
 White/Caucasian Native Hawaiian/Other Pacific Islander Other: _____ Refused

* Documentation in the patient's medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs)

IF ORDERING MULTIPLE PANELS, EACH PANEL WILL REQUIRE ITS OWN COLLECTION TUBE

URINARY TRACT INFECTION TESTS
BD Vacutainer C&S Tube (gray)

Urinalysis *UA Preservative Tube Required*
 Complete UTI Panel with Antibiotic Resistance Menu w/ Sensitivity

Urinary Tract Infection Menu	Antibiotic Resistance Menu
<input type="checkbox"/> Acinetobacter baumannii	<input type="checkbox"/> Beta-lactamase (blaKPC)
<input type="checkbox"/> Candida albicans	<input type="checkbox"/> Beta-lactamase (CTX-M-Group 1)
<input type="checkbox"/> Candida glabrata	<input type="checkbox"/> Metallo-Beta-lactamase (blaNDM)
<input type="checkbox"/> Citrobacter freundii	<input type="checkbox"/> Fluoroquinolones
<input type="checkbox"/> Enterobacter cloacae	<input type="checkbox"/> Methicillin/Oxacillin (mecA)
<input type="checkbox"/> Enterococcus spp.	<input type="checkbox"/> Sulfonamides
<input type="checkbox"/> Escherichia coli	<input type="checkbox"/> Trimethoprim
<input type="checkbox"/> Klebsiella pneumoniae	
<input type="checkbox"/> Morganella morganii	
<input type="checkbox"/> Proteus mirabilis	
<input type="checkbox"/> Pseudomonas aeruginosa	
<input type="checkbox"/> Staphylococcus aureus	
<input type="checkbox"/> Staphylococcus saprophyticus	
<input type="checkbox"/> Streptococcus agalactiae	

RESPIRATORY PATHOGEN TESTS
Respiratory and Viral Transport Medium (red top)

Respiratory Pathogen Menu

Influenza A (incl. H1, H3, H5, and H7)
 Influenza B (Yamagata and Victoria lineages)
 Respiratory Syncytial Virus (incl. type A and B)
 SARS-CoV2-2 a
 SARS-CoV2-2 b

SEXUALLY TRANSMITTED INFECTION TESTS
BD Vacutainer C&S Tube (gray) OR E-swabs

Complete STI Panel with Resistance Markers & Pathogenic Flora

Chlamydia trachomatis Mycoplasma hominis
 HSV-1 (Herpes-Simplex) Neisseria gonorrhoeae
 HSV-2 (Herpes-Simplex) Trichomonas vaginalis
 Mycoplasma genitalium Ureaplasma urealyticum

BACTERIAL VAGINOSIS PANEL *E-Swabs*

Complete Panel

<input type="checkbox"/> Atopobium vaginae	<input type="checkbox"/> Candida krusei	<input type="checkbox"/> Lactobacillus gasseri
<input type="checkbox"/> Candida albicans	<input type="checkbox"/> Candida parapsilosis	<input type="checkbox"/> Lactobacillus iners
<input type="checkbox"/> Candidi glabrata	<input type="checkbox"/> Candida tropicalis	<input type="checkbox"/> Lactobacillus jensenii
	<input type="checkbox"/> Gardnerella vaginalis	<input type="checkbox"/> Trichomonas vaginalis
	<input type="checkbox"/> Lactobacillus crispatus	

Group A Streptococcus
Nasopharyngeal Swab

AUTHORIZATION/SIGNATURES

DONOR: I certify that the specimen and information provided is my own and has not been substituted or adulterated. I further grant permission for the testing of my specimen for the presence of drugs and/or alcohol. I authorize Birdrock Laboratories to share the information on this form and my test results with my designated insurance carrier if necessary for reimbursement, to appeal any reimbursement denial, and authorize all reimbursements to be paid directly to the laboratory in consideration of services performed. I acknowledge that Birdrock Laboratories may be outside my network of insurance and I may be responsible for the amount due as determined by said insurance. I authorize Birdrock Laboratories to release the results of this testing to the treating authorized healthcare provider or facility.

ORDERING PROVIDER: Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. I certify that the above ordered tests are medically necessary for the diagnosis and treatment of this patient. I have documented this test in the patient's chart. I acknowledge that Medicare does not generally cover routine screening tests.

The patient understands and agrees that the patient's leftover specimen and clinical information may be used, without information directly identifying the patient, for research, education, and other business purposes of Birdrock Laboratories (each a "secondary use" and together "secondary uses"). The patient understands that this may involve Birdrock Laboratories sharing the patient's leftover specimen and clinical information with other third parties. The patient's leftover specimen and clinical information will be assigned a unique code before any secondary uses. The patient's name or other personal identifying information will not be used in or linked to the patient's specimen and clinical information when they are shared with third parties unless the patient explicitly authorizes that disclosure. Furthermore the leftover specimen will become the property of Birdrock Laboratories. The specimens could lead to discoveries or inventions that may be of value to Birdrock Laboratories or to other organizations. You do not have any right to money or other compensation stemming from products that may be developed from the specimens unless expressly required under applicable state law.

Donor Authorization Signature: _____	Date: _____	Ordering Health Care Provider Signature (Required): _____	Date (Required): _____
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DIAGNOSIS (ICD-10) CODES

Commonly Used ICD-10 Diagnosis Codes

UA/UTI Codes

B30.9 - Viral conjunctivitis	N39.4X - Other specified urinary incontinence	R21 - Rash and other nonspecified skin conditions
B37.41 - Candidal cystitis and urethritis	N39.41 - Urge incontinence	R31.1 - Benign essential microscopic hematuria
B37.49 - Other urogenital candidiasis	N41.0 - Acute prostatitis	R32 - Unspecified urinary incontinence
M25.5X - Joint disorders (various)	N41.8 - Other inflammatory diseases of prostate	R33.X - Retention of urine
N02.x - Recurrent and persistent hematuria	N76.0 - Acute vaginitis	R35.0 - Frequency of micturition
N30.1X - Interstitial cystitis (chronic)	O23.1X - Infections of bladder in pregnancy	R50.9 - Fever (unspecified)
N30.11 - Interstitial cystitis (chronic) with hematuria	O23.2X - Infections of urethra in pregnancy	Z03.89 - Observation for other suspected conditions
N30.2X - Other chronic cystitis	O23.4X - Unspecified infection of urinary tract in pregnancy	Z11.X - Encounter for screening for infections and parasitic diseases
N34.1 - Nonspecific urethritis	O23.9X - Other and unspecified genitourinary tract infection in pregnancy	Z87.440 - Personal history of urinary (tract) infections
N34.2 - Other urethritis	R10.30 - Lower abdominal pain, unspecified	Other: _____
N39.0 - Urinary tract infection, site not specified		

Respiratory Codes

J02.9 - Acute Pharyngitis	J03.90 - Acute Tonsillitis	R05.X - Cough
J01.90 - Acute Sinusitis, Unspecified	J31.0 - Unspecified Rhinitis	R06.02 - Shortness of breath
J00 - Acute Nasopharyngitis	J06.9 - Acute Upper Respiratory Infections of Unspecified Site	Z11.59 - Encounter for screening for other viral diseases
J43.2 - Centriacinar Emphysema (HCC)	J40 - Bronchitis, Unspecified	Z20.828 - Contact with (and suspected exposure to) other viral communicable diseases
J32.9 - Unspecified Sinusitis, Chronic	J44.9 - COPD	Other: _____
J43.9 - Emphysema, Unspecified	J43.2 - Emphysema, Centrilobular	
J44.9 - Asthma with chronic obstructive pulmonary disease (COPD) (HCC) J01.90 Acute Sinusitis, Unspecified	R91.1 - Pulmonary Nodule, Solitary	
	R50.9 - Fever, unspecified	

Testing performed by Birdrock Laboratories is compliant with all local and state guidelines and regulations. Any testing performed at our facility is based on current coding:

- CPT **87798** - Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism.
- CPT **87640** - Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique.
- CPT **87641** - Staphylococcus aureus, methicillin resistant, amplified probe technique.
- CPT **87653** - Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique.
- CPT **87481** - Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique.
- CPT **87150** - Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed.
- CPT **81002** - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents.

All tests ordered for Medicare or Medicaid reimbursement must meet the program's requirements or the claim may be denied. Testing should **ONLY** be performed when it is considered medically necessary by a qualified healthcare professional.