H&M Molecular Diagnostics
10581 Roselle Street, Suite 120, San Diego, CA 92121
Michael Maymind, MD, Lab Director
CLIA#: 05D2158603 (858)258-9493
cs@integrity-sciences.com

Section 1: Patient Information

Name (Last, First, M.I.) COMPANY NAME

Street Address City State Zip

Date of Birth (MM/DD/YYYY) Gender ☐ Female ☐ Male Phone

Payment
☐ Private Insurance ☐ Self-Pay ☐ Client Bill ☐Medicare ☐ Medicaid ☐ Employer Pay
ATTACH A COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

Section 2: Ordering Physician

Physician Name Practice Name NPI

Section 3: Specimen Information

Date Collected (MM/DD/YYYY) Time Collected (HH:MM) ☐ AM ☐ PM

Collection Type
☐ Nasopharyngeal swab ☐ Collector's Initials

Section 4: Test Requested

☐ SARS-CoV-2

ICD-10 CODES
The following are provided for the physician's convenience only.
Please Check all the codes that apply
☐ R50.9 Fever, unspecified
☐ R05 Cough
☐ R06.02 Shortness of Breath
☐ Z11.59 Encounter for screening for other viral diseases
☐ Z20.828 Contact with and (suspected (exposure to other viral communicable diseases
☐ Other _____

Section 5: Patient Consent

I request and authorize a CLIA-certified laboratory to perform the above 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 test which have been explained to my satisfaction by a qualified health professional. Assignment of Benefits: If applicable, I hereby authorize H&M Molecular Diagnostics, LLC 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 all charges associated with its collection. I hereby authorize my insurance company to pay H&M Molecular Diagnostics, LLC directly for services rendered. Appeal Authorization: If applicable, in the event of an underpayment or denial by my insurance carrier, I hereby authorize H&M Molecular Diagnostics, LLC 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, medical review officer or my employer. I authorize H&M Molecular Diagnostics to release any information required for billing purposes. Acknowledge that H&M Molecular Diagnostics be an out of network provider with my insurer. I also agree that in a case where my insurance provider send payment directly to me, I will endorse the insurance check and forward it to H&M Molecular Diagnostics within 30 days. I understand that the failure to do so may result in my account being forwarded to collection and reported to a credit bureau.
Release: I further agree that I and my heirs, executors and assigns hereby release my employer, H&M Molecular Diagnostics, including its employees, agents, affiliates, and contractors from any and all liability and claims.

* H&M Molecular Diagnostics, LLC and/or designee may perform this appeal on my behalf but is not obligated to do so.

X
Patient Signature Date _____

Section 6: Authorized Healthcare Provider Acknowledgement

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity

X Patient Signature Date _____