Test Requisition Form

COVID-19 IMMUNE INDEX™

www.immuneindex.com

KSL Diagnostics
1000 Youngs Road, Suite 210
Buffalo NY 14221 USA
1-833-COVINDEX
info@immuneindex.com

PATIENT

LAST NAME	FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	
MED REC#/PATIENT IDENTIFIER	ETHNICITY/RACE	
PATIENT ADDRESS		
CITY	STATE/PROVINCE	POSTAL CODE
PHONE	EMAIL	

PHYSICIAN/PHARMACIST

INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL	
PROVIDER LAST NAME	PROVIDER FIRST NAME	
NPI (USA)/MINC (CANADA)	PROVIDER TITLE (MD, DO)	
PROVIDER ADDRESS		
CITY	STATE/PROVINCE	POSTAL CODE
PROVIDER PHONE	FAX REPORT TO	
PRIMARY CONTACT	PRIMARY CONTACT PHONE/EMAIL/FAX	
PHYSICIAN/PHARMACIST SIGNATURE X		

☐ **Patient consent for specimen collection by KSL Diagnostics:** I authorize KSL Diagnostics to obtain a swab sample and/or blood sample as required by the test(s) requested for the purpose of determining specific laboratory test levels.

☐ **Patient consent for Research:** I have read the Informed Consent document and I give permission to KSL Diagnostics to perform testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at KSL Diagnostics and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. ☐ Opt out of research ☐ Check this box if you are a New York state resident and give permission for KSL to retain any remaining sample longer than 60 days after the completion of testing.

PATIENT SIGNATURE (OR GUARDIAN SIGNATURE, IF PATIENT IS A MINOR) — REQUIRED FOR BILLING PURPOSES X	DATE (MM/DD/YYYY)

By signing above, the patient or payor authorizes KSL Diagnostics to contact them directly, and use the provided billing instructions to bill the indicated method.

SELECT ALL TESTS REQUESTED

COVID-19 ANTIBODY TESTS:

☐ **231 COVID-19 Immune Index™ — IgG, IgM, IgA Antibody Testing by CLIA Correlated with Virus Neutralization**

SAMPLE REQUIREMENTS

- **Dried Blood Spot (DBS):** Dried blood spots collected and dried on an appropriate DBS card. Fill circles completely and evenly to the outer edge. Reverse side should look the similar to the front. Dry the DBS card for 1 hour prior to packaging for shipping.
- **Serum/Plasma – Serum Separator Tube preferred:** Absolute minimum volume: 1mL; Serum stable at: ambient temperature, 48 hours; refrigerated, 2 weeks; frozen, 2 years. If possible, separate serum from cells after 30 minutes but within 2 hours. If unable to separate serum, send to lab in 48 hours of draw.

ADDITIONAL COVID-19 ANTIBODY TESTING:

☐ **234 Coronavirus Disease (COVID-19) Total Ab, Nucleocapsid**

☐ **238 Comprehensive COVID-19 Antibody Panel — Includes Tests 231, 234**

SAMPLE REQUIREMENTS

- **Serum/Plasma – Serum Separator Tube preferred:** Absolute minimum volume: 1mL; Serum stable at: ambient temperature, 48 hours; refrigerated, 2 weeks; frozen, 2 years. If possible, separate serum from cells after 30 minutes but within 2 hours. If unable to separate serum, send to lab in 48 hours of draw.

SAMPLE TYPE (CHECK ALL THAT APPLY)

☐ DBS ☐ SERUM ☐ PLASMA	COLLECTION DATE (MM/DD/YYYY)

ICD-10 CODES — SELECT/INDICATE ICD-10 CODE(S)

☐ **Z23 Encounter for Immunization** ☐ **Z01.84 Encounter for Antibody Response**
☐ **Z86.16 Personal History of COVID-19** ☐ **U07.1 Current COVID-19 Infection**

SHIPPING INSTRUCTIONS

- **Label each specimen with at least two unique identifiers that match the Test Requisition Form (e.g., patient first and last name, DOB, MRN).**
- **Insert all paperwork into outside pocket of the specimen bag.**

SEND COMPLETED FORM WITH SAMPLE(S) TO:

- **KSL Diagnostics**
  1000 Youngs Road, Suite 210
  Buffalo, NY 14221 USA

INSURANCE BILLING

ATTACH FRONT AND BACK OF ALL INSURANCE CARDS, ABN, MEDICAL CRITERIA FORM

BY SIGNING ABOVE, THE PATIENT OR INSURED AUTHORIZES KSL DIAGNOSTICS TO RELEASE MEDICAL INFORMATION CONCERNING THE TEST TO THE ASSIGNED INSURANCE COMPANY.

ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE		REFERRAL/PRIOR AUTH	KSLDX ID #
PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)