

ANTIBODY TEST



PRIMARY PATIENT			
LAST NAME		FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)		GENETIC SEX <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	
MED REC#/PATIENT IDENTIFIER		ETHNICITY	
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE		EMAIL	
SAMPLE TYPE <input type="radio"/> WHOLE BLOOD <input type="radio"/> PLASMA <input type="radio"/> SERUM		COLLECTION DATE (MM/DD/YYYY)	

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

I have read the Informed Consent document and I give permission to Fulgent Genetics to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Fulgent 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. More information is available at www.fulgentgenetics.com/policies/privacy-policy.

- Opt out of research
- Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after the completion of testing.

I attest that the patient has received and read the Fulgent Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Fulgent Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) X	DATE (MM/DD/YYYY)
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ORDERING PROVIDER SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)
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TEST REQUESTED	
TEST NAME COVID-19 Test by IgM/IgG Antibody Detection	ICD-10 CODES - Select/indicate ICD-10 code(s)
SAMPLE REQUIREMENTS Whole blood, plasma, or serum specimen (Purple top EDTA tubes or Yellow top ACD tubes)	<input type="checkbox"/> Pneumonia (COVID-19) <small>J12.89 Pneumonia, Other viral pneumonia B97.29 Pneumonia, Other coronavirus</small>
SHIPPING INSTRUCTIONS a. Specimens must be stored at 2-8°C prior to shipping. b. Express delivery within 24 hours from collection. c. Ship specimens with cold packs (recommended for plasma and serum). d. Specimens must be labeled with two patient identifiers. e. All specimens must be accompanied by a completed TRF. All paperwork must be inserted into the OUTSIDE pocket of the specimen bag. Samples will be REJECTED if paperwork is in the same compartment as the sample. f. Send completed TRF with collected sample to: Fulgent Genetics 4978 Santa Anita Ave. Temple City, CA 91780	<input type="checkbox"/> Lower Respiratory Infection (COVID-19) <small>J22: Acute lower respiratory infection, Unspecified B97.29 Pneumonia, Other coronavirus</small>
	<input type="checkbox"/> Acute Bronchitis (COVID-19) <small>J20.8 Acute Bronchitis, Unspecified B97.29 Pneumonia, Other coronavirus</small>
	<input type="checkbox"/> Bronchitis (COVID-19) <small>J40 Bronchitis, Unspecified B97.29 Pneumonia, Other coronavirus</small>
	<input type="checkbox"/> Z03.818 Suspected exposure to COVID-19 <input type="checkbox"/> Z20.828 Known Exposure to COVID-19
	<input type="checkbox"/> R05 Cough <input type="checkbox"/> R06.02 Shortness of Breath <input type="checkbox"/> R50.9 Fever, Unspecified <input type="checkbox"/> J01.90 Acute Sinusitis, Unspecified <input type="checkbox"/> J02.9 Acute Pharyngitis, Unspecified <input type="checkbox"/> J06.9 Acute Upper Respiratory Infection, Unspecified <input type="checkbox"/> J18.9 Pneumonia, Unspecified organism <input type="checkbox"/> J20.9 Acute Bronchitis, Unspecified <input type="checkbox"/> J32.9 Chronic Sinusitis, Unspecified <input type="checkbox"/> Other:

INSURANCE BILLING				Attach front and back of all insurance cards, ABN, medical criteria form			
PLEASE ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE	REFERRAL/PRIOR AUTH	FULGENT BENEFITS ID #	By signing above, the patient or insured authorizes Fulgent Genetics to release medical information concerning the test to the assigned insurance company.			
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)			

INSTITUTIONAL BILLING			
INSTITUTION/PRACTICE NAME			
ATTENTION TO			
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE		FAX/EMAIL	

SELF PAY			
<input type="radio"/> Use patient information above for billing <input type="radio"/> Use information below for billing		By signing above, the patient or payor authorizes Fulgent Genetics to contact them directly, and use the provided billing instructions to bill the indicated method.	
PAYOR LAST NAME		PAYOR FIRST NAME	
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE		FAX/EMAIL	