RSM—Patient Direct Drop Shipment Request Form

This form is a request for RSM Diagnostics Lab to ship a test collection kit, including a blank Test Requisition Form (TRF), directly to an individual patient. This form is for authorized practice and facility personnel only and does not itself constitute a laboratory order. RSM will not accession, process, or perform any test until the completed and signed TRF included in the kit is returned with the specimen.

If you are able to place this order through RSM's KOLIMS Provider Portal, we recommend doing so at **app.kolims.com.**
This form is intended for exceptional cases in which you have been directed to use this form instead.
If you need guidance, onboarding, or a walkthrough for the KOLIMS Provider Portal, contact RSM Diagnostics Lab at **302-592-4106** or **info@rsmdiagnosticslab.com.**

RSM Diagnostics Lab does not offer services in New York or California. RSM will not accept, perform, process, ship, deliver, bill, or receive testing associated in any manner with either state, including any patient with a New York or California address, any specimen collected in, shipped from, shipped to, routed through, or otherwise connected to either state, or any account, practice, provider, or facility located in or operating from either state. Do not submit a request through this form for a patient located in New York or California.

This form collects only the information needed to prepare and ship the kit; complete clinical documentation, diagnosis coding sufficiency, and payment or billing information are handled separately through the returned TRF and RSM's standard billing procedures.

The practice or facility's primary contact KOLIMS administrator account email address is required below to support response editing, follow-up communication, and order coordination.

Complete all required fields accurately, as incomplete or inconsistent information may delay kit shipment.

By submitting this form, you confirm that you are authorized to submit this request on behalf of the practice or facility. RSM's separate contractual terms, privacy notices, and regulatory obligations govern laboratory services and data handling. This form does not modify those terms.

Select **Next** to continue.

***INDICATES REQUIRED FIELD**

* Indicates required question

1. Email *

RSM Diagnostics Lab

Contact Information

RSM Diagnostics Lab LLC

2500 Grubb Rd, Suite 120
Wilmington, DE 19810

- Email: info@rsmdiagnosticslab.com
- Website: www.rsmdiagnosticslab.com
- Phone: **302-592-4106** (Mon-Fri 8:30am-4:30pm)
- Fax: **877-366-4706**

1. ENTER PATIENT INFORMATION BELOW

Section 1: Patient Information

Enter the patient's information exactly as it appears in the patient record. Verify the mailing address carefully. RSM will use this information to coordinate direct kit shipment and related patient communication.

2. *Patient First Name: *

   Enter the patient's legal first name.

3. *Patient Last Name: *

   Enter the patient's legal last name.

4. *Patient Date of Birth: *

   Enter the patient's date of birth.

   Example: January 7, 2019

5. *Patient Sex: *

   Mark only one oval.

   - Male
   - Female

6. *Patient Phone: *

   Enter the best valid 10-digit phone number for patient communication, including extension if applicable.
   Example: 555-555-5555 ext. 123.

7. *Patient Email: *

   Enter the best email for patient communication.
   Example: patient@example.com

8. *Patient Street Address: *

   Enter the complete street address, including apartment, unit, or suite number if applicable. Do not enter a P.O. Box unless it is an approved delivery address.

9. *Patient City: *

   Enter the city exactly as used for postal delivery.

10. *Patient State: *

    Use the full list of U.S. states and jurisdictions RSM is authorized to ship to. RSM does not offer services in New York or California; these states are not available for selection.

11. *Patient Zip: *

    Enter a valid five-digit ZIP Code or ZIP+4 format.
    Example: 19810 or 19810-1234.

2. ENTER PROVIDER INFORMATION BELOW

Section 2: Provider Information

Enter the practice or facility and the provider responsible for ordering the selected test(s). The ordering provider must be authorized under applicable law to order the requested laboratory services and must be the practitioner responsible for the patient's care and use of the test result(s).

12. *Practice / Facility Name (enter on line below): *

    Enter the practice or facility name exactly as it appears in the RSM account and KOLIMS portal.

13. *Ordering Provider (enter one provider below): *

    Enter the full name of the RSM-approved ordering provider on file for this practice or facility. RSM will match this name to the provider's approved NPI already on record.

    Enter one provider in the following format:
    Title. FirstName LastName, Credential

    Examples (enter only one ordering provider):
    Dr. Jane Doe, MD
    Mr. John Doe, FNP
    Dr. Maria Smith, ND

3. MAKE TEST SELECTION BELOW*

Section 3: Test Selection

14. **MAKE TEST SELECTION BELOW*** *

Mark only one oval.

- ◯ Upper Respiratory Microscreen
- ◯ Total GI
- ◯ EGHA

15. Enter other(s) or addon(s) below:

4. ENTER ICD-10 DIAGNOSIS CODE(S) BELOW*

Section 4: ICD-10 Diagnosis Code(s)
Enter the ICD-10-CM diagnosis code or codes that support the medical necessity of the selected test(s). Enter one code per line. The diagnosis information entered here must be consistent with the ordering provider's clinical documentation in the patient record.

16. **ENTER ICD-10 DIAGNOSIS CODE(S) BELOW*** *

Enter the ICD-10-CM diagnosis code or codes that support the medical necessity of the selected test(s). Enter one code per line. The diagnosis information entered here must be consistent with the ordering provider's clinical documentation in the patient record.

5. REVIEW, AUTHORIZE, & CERTIFY PRELIMINARY ATTESTATION

5. Preliminary Attestation

17. **Name of Individual Completing This Form*** *

Enter your full name. You must be the ordering provider or an authorized representative submitting this request on the ordering provider's behalf.

18. **Submission Authority*** *

Mark only one oval.

- I am the ordering provider.
- I am authorized by the ordering provider to submit this request on the provider's behalf.

Preliminary Attestation Statement*

By submitting this request, I confirm that the information provided is accurate and that the ordering provider identified above is expected to order the selected test(s) for this patient. I understand this form is a request to ship a test collection kit, including a blank Test Requisition Form (TRF), to the identified patient, and that this form does not constitute a completed laboratory order.

I understand that RSM Diagnostics Lab will not process, accession, or perform any test until the completed and signed TRF included in the shipped kit is returned with the specimen. I understand that the returned TRF, not this form, is the operative document establishing medical necessity, patient consent, and the ordering provider's certification and authorization to order the selected test(s), and that any information provided here is subject to confirmation by the completed TRF.

19. **Do you certify that you have read, understand, and agree to the statement above, and that the information provided in this request is accurate to the best of your knowledge?** *

Mark only one oval.

- ( ) I certify that I have read, understand, and agree to the statement above, and that the information provided in this request is accurate to the best of my knowledge.

Submission*

Read and acknowledge the Administrative, Privacy, and Compliance Notice below before submitting.*

Administrative, Privacy, and Compliance Notice*

This form is a request to ship an RSM Diagnostics Lab test collection kit, including a blank Test Requisition Form (TRF), to the identified patient. This form is not a laboratory order, is not a substitute for the patient's medical record or the ordering provider's clinical documentation, and does not initiate specimen testing. RSM Diagnostics Lab will not accession, process, or perform any test until the completed and signed TRF included in the shipped kit is returned with the specimen. The returned, signed TRF is the operative document for purposes of medical necessity, patient consent, and ordering provider certification and authorization.

New York and California. RSM Diagnostics Lab does not offer services in either state. RSM will not accept, perform, process, ship, deliver, bill, or receive testing associated in any manner with New York or California, including any patient with a New York or California address, any specimen collected in, shipped from, shipped to, routed through, or otherwise connected to either state, or any account, practice, provider, or facility located in or operating from either state.

This form contains protected health information (PHI), including patient identifiers, contact information, and diagnostic information. This form is hosted within RSM's HIPAA-compliant Google Workspace environment, and RSM has executed a Business Associate Agreement with Google governing the processing of PHI within that environment. Access to this form and its responses is restricted to authorized RSM and practice personnel with a legitimate need to access the information, consistent with the HIPAA minimum necessary standard.

By submitting this form, you confirm that:

- You are an authorized representative of an existing RSM Diagnostics Lab account and are permitted to submit this request on behalf of the identified practice or facility and ordering provider.
- All information provided is accurate, complete, and consistent with the patient's medical record to the best of your knowledge.
- The ordering provider identified in this form is the individual RSM has on file as authorized to order the selected test(s) for this practice or facility, and that provider's National Provider Identifier (NPI) on file with RSM will be associated with this order.
- Required patient consent for specimen collection, testing, and release of results has been obtained by the ordering provider or practice before this request is submitted.

Submission of this form does not itself constitute a completed test requisition, does not replace any specimen collection or laboratory requisition documentation required at the time of specimen submission, and does not guarantee test performance, insurance coverage, or reimbursement. Coverage and billing determinations remain subject to the patient's insurance plan, medical necessity requirements, and applicable federal and state law, including Medicare and other payer-specific rules.

RSM Diagnostics Lab maintains separate CLIA certification, laboratory quality procedures, HIPAA privacy and security policies, and billing and compliance procedures governing test performance, PHI handling, and claims submission. This form and this notice support administrative and clinical intake for this request and do not modify, limit, or substitute for those separate policies, RSM's Notice of Privacy Practices, or any provider or facility services agreement.

RSM Diagnostics Lab reserves the right to decline, delay, or request clarification of any request submitted through this form where information is incomplete, inconsistent, unauthorized, or insufficient to support test performance or billing under applicable law.

20. **Did you read and acknowledge the Administrative, Privacy, and Compliance Notice above?** *

Mark only one oval.

- ( ) I have read and acknowledge the Administrative, Privacy, and Compliance Notice above.

21. Additional Questions, Comments, Concerns, or Notes (optional)

This field is optional.
Use this space to share any additional information, questions, comments, concerns, or notes you would like RSM to know.

RSM Diagnostics Lab

Contact Information

RSM Diagnostics Lab LLC

2500 Grubb Rd, Suite 120
Wilmington, DE 19810

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