Test Requisition Form

RSM Diagnostics Lab
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*** INDICATES REQUIRED FIELD**

1. WRITE PATIENT INFORMATION BELOW

*First Name: _____

*Last Name: _____

*Date of Birth: _____ *Sex: _____ *Phone: _____

*Email: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

2. WRITE PROVIDER INFORMATION BELOW

*Practice / Facility Name (write on line below):

_____

*Referring Provider (write one provider below):

Fmt: TITLE. FIRST & LAST, CREDS
E.g. Mr. John Doe, FNP | E.g. Dr. Maria Smith, MD

_____

COMPLETE SECTIONS NUMBERED 1 - 8

3. MAKE TEST SELECTION BELOW*

☐ Upper Respiratory Microscreen

☐ Total GI

☐ EGHA

Write other(s) or addon(s) below:

_____

_____

_____

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

_____

_____

_____

5. FILL SPECIMEN INFORMATION BELOW

*Specimen Type (select one): ☐ Stool or ☐ Nasal & Throat Swab

*Collected By (name): _____

*Date and Time Collected: _____

6. ACKNOWLEDGE CLINIC BILLING MODEL

The practice / facility will collect payment and perform billing.

☐ I understand that the ordering practice / facility where I am a patient will collect payment and perform any billing.*

7. REVIEW PROVIDER CERTIFICATION

By completing and submitting this test requisition and associated specimen, I certify that the ordered test(s) are medically necessary for the diagnosis or management of this patient, that required patient consent for specimen collection, testing, and release of results has been obtained, and that I am authorized under applicable law to order these test(s). I understand that RSM Diagnostics LLC will accession this requisition and specimen as a laboratory order in its KOLIMS system and will associate the order with my name and NPI, and that additional clinical documentation supporting this order and its medical necessity is maintained in the patient's medical record and will be available upon request.

*System-generated or **hand-written signature above,** or authenticated provider selection in KOLIMS, serves as the ordering provider's signature.*

8. READ AND SIGN PATIENT CONSENT & AUTHORIZATION

I acknowledge that my provider has explained the test(s) requested on this form and that I am voluntarily providing a specimen for analysis. I acknowledge that my healthcare provider has explained the tests requested on this form and that I am voluntarily providing a specimen for analysis. I authorize my provider to release the specimen and medical records to RSM Diagnostics LLC. I acknowledge that the medical facility handles all billing matters, and RSM Diagnostics LLC will not seek payment from me or my insurance provider. I understand that if all required fields marked with a red asterisk (*) and sections 1 through 8 are not fully completed, this TRF will be considered incomplete and may result in sample kit return and specimen denial, in which case testing will not be performed.

*PATIENT SIGNATURE: _____ *DATE: _____

If all fields marked with a red asterisk (*) are not completed and sections 1 through 8 are incomplete, the TRF will be considered incomplete. Incomplete TRFs may result in return of the sample kit and specimen denial, in which case testing will not be performed.

The ordering provider remains responsible for documenting the specific diagnosis, intent to order, and medical necessity in the patient's medical record and for supplying any ICD-10 code or supporting documentation required for billing or coverage. The referring provider selected or printed on this requisition is recorded in KOLIMS as the ordering provider for this test. By submitting this requisition and specimen, that provider is deemed to have authorized the order, and the authenticated provider selection or system-generated signature in KOLIMS may serve as evidence of that authorization. RSM Diagnostics LLC is not responsible for missing, incomplete, or unsupported diagnosis coding or medical necessity documentation supplied by the referring provider.