Acūtis

Acutis Reveal™ test requisition: RIT/PIT/GIT/COVID-19

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service@acutis.com
CLIA ID 33D2087537 PFI 8944

Specimen identifier stickers

Date of birth ... / ... / ... Date of birth ... / ... / ...
Patient name ... Patient name ...

A Enter key information

Provide the ICD-10 diagnosis code

DIAGNOSIS CODE(S)* ... Required

Please ensure this information matches with patient notes in the office's EHR.

Account number ...

Patient demographics

Last name* ... First name* ... MI ...
Date of birth* ... / ... / ... Gender ☐ M ☐ F
Address ... City ... State ... Zip ...
Phone number ... Email ...

Insurance information

☐ Copy of insurance card(s) attached*
Primary insurance carrier* ...
Policy I.D.#* ... Group* ...
☐ Self-pay

*Required fields

B Order targets based on medical necessity

Acutis Reveal™ Respiratory Infection Test (RIT)

Nasopharyngeal swab

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

*Choosing more than 5 pathogens may not be considered medically necessary by some health plans.

☐ Common viral infections
(Checking box will indicate all common viral pathogens listed below)

- ☐ Influenza A
- ☐ Influenza H1/H3
- ☐ Influenza B
- ☐ Respiratory syncytial virus A
- ☐ Respiratory syncytial virus B

☐ Bacterial infections
(Checking box will indicate all bacterial pathogens listed below)

- ☐ *Chlamydophila pneumoniae*
- ☐ *Mycoplasma pneumoniae*

Other viral infections

- ☐ Adenovirus
- ☐ Parainfluenza virus 1
- ☐ Parainfluenza virus 2
- ☐ Parainfluenza virus 3
- ☐ Parainfluenza virus 4
- ☐ Coronavirus HKU1
- ☐ Coronavirus NL63
- ☐ Coronavirus 229E
- ☐ Coronavirus OC43
- ☐ Human bocavirus
- ☐ Human metapneumovirus
- ☐ Rhinovirus / Enterovirus

Acutis Reveal™ Pharyngeal Infection Test (PIT)

Pharyngeal swab in Amies media

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

☐ Perform PCR for detection of PIT pathogen(s) and ABRG below
(Checking box will indicate you are ordering all targets listed below)

- ☐ *Arcanobacterium haemolyticum*
- ☐ *Candida albicans*
- ☐ *Chlamydophila pneumoniae*
- ☐ *Corynebacterium diphtheriae*
- ☐ *Cryptococcus neoformans*
- ☐ *Haemophilus influenzae*
- ☐ *Moraxella catarrhalis*
- ☐ *Mycoplasma pneumoniae*
- ☐ *Streptococcus pyogenes*
- ☐ *Staphylococcus aureus*
- ☐ *methicillin-resistant Staphylococcus aureus (mecA)*

Acutis Reveal™ Gastrointestinal Infection Test (GIT)

Cary-Blair media

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

*Choosing more than 5 pathogens may not be considered medically necessary by some health plans.

☐ Bacterial (Checking box will indicate all viral pathogens below to bacterial)

- ☐ *Campylobacter jejuni / coli / lari*
- ☐ *Escherichia coli* O157
- ☐ Enterotoxigenic *Escherichia coli* (ETEC) LT / ST
- ☐ *Salmonella*
- ☐ Shiga-like toxin producing *Escherichia coli* (STEC) stx 1 / stx 2
- ☐ *Shigella boydii / sonnei / flexneri / dysenteriae*
- ☐ *Vibrio cholerae* toxin (ctx)

☐ Parasitic (Checking box will indicate all viral pathogens below to parasitic)

- ☐ *Cryptosporidium parvum / hominis*
- ☐ *Giardia lamblia*
- ☐ *Entamoeba histolytica*

☐ Add on Viral Testing**

**This test includes positive or negative results for Adenovirus 40/41, Norovirus GI/GI, Rotovirus A and will not include results for individual targets

☐ Add on Clostridium difficile toxin A/B***

***Selecting this checkbox will include this pathogen in the Acutis Reveal™ GIT bacterial test menu.
According to the Centers for Disease Control and Prevention, and the Infectious Diseases Society of America, Clostridium difficile testing should not be routinely performed in children with diarrhea who are less than 2 years of age unless other infectious or noninfectious causes have been excluded.

Acutis Reveal™ COVID-19

Nasopharyngeal swab

Date collected ... / ... / ... Time ... : ... ☐ AM ☐ PM

☐ SARS-CoV-2 (COVID-19)

C Patient authorization

The specimen I have provided was done so voluntarily and I authorize Acutis Diagnostics to process, bill and provide results. I acknowledge and agree to the terms of the Patient Authorization and Assignment of Benefits on the back of this form.

Patient signature* ... Date ... / ... / ...

For laboratory use only
Date / time received

D Provider authorization

I certify that I have ordered all testing listed above for the medically necessary monitoring, care and treatment of above listed patient. I acknowledge that documentation to support medical necessity for all test(s) ordered is recorded in the patient's chart. I further acknowledge and agree to the Provider Authorization and Certification of Medical necessity on the back of this form.

Authorized healthcare provider signature* ... Date ... / ... / ...

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Patient authorization and irrevocable assignment of benefits

I certify that the sample was provided without tampering. I authorize Acutis Diagnostics to release the results to the ordering provider. The laboratory is authorized to bill my insurance provider(s), or any payer, whether fully or partially insured and I will irrevocably assign any payment of benefits, claims, appeal rights and interest related to the services performed by the laboratory with any payer.

I understand that in some cases, Acutis may be out-of-network or that my insurer will send payment directly to me. In the event payment is made to me, I agree to endorse the insurance check and forward it to Acutis within 30 days. My failure to forward the insurance check may result in my account being forwarded to collections or to a credit bureau. If related to no fault, I authorize assignment of benefits towards payment of services provided by Acutis. I understand that I may be responsible for charges after processing by insurance including deductible and copay/coinsurance. In the event I do not have insurance coverage, I may be fully responsible for all charges.

Provider authorization and certification of medical necessity

I acknowledge all tests are reasonable, appropriate, and medically necessary for the monitoring, care, and treatment of the patient, as documented by the patient's records. Acutis Diagnostics emphasizes the importance of testing based on medical necessity. I agree to provide documentation upon request, from the patient's medical chart, supporting medical necessity of tests ordered within 15 days of the request.

I acknowledge a listing of all applicable CPT/HCPCS codes will be made available to me upon request from the laboratory. I further acknowledge the laboratory's Annual Provider Notice is available on their website.

For Reveal™ Respiratory Infection Test (RIT)

Please note that the performance of this test has not been established for patients without signs and symptoms of respiratory infection. Results from this test must be correlated with the clinical history, epidemiological data, and other data available to the practitioner who is evaluating and/or treating the patient. Viral and bacterial nucleic acids may persist in vivo independent of organism viability.

For Reveal™ Gastrointestinal Infection Test (GIT)

Please note that the performance of this test has not been established for patients without signs and symptoms of gastrointestinal illness. Virus, bacteria and parasite nucleic acid may persist in vivo independently of organism viability. Results from this test must be correlated with the clinical history, epidemiological data, and other data available to the practitioner who is evaluating and/or treating the patient. Additionally, some organisms may be carried asymptomatically.

For Reveal™ COVID-19 PCR

This test is being offered under an FDA Emergency Use Authorization (EUA) and is only authorized for the duration of time that circumstances exist justifying the authorization of the emergency use of in vitro diagnostic tests for detection of SARS-CoV-2 virus and/or diagnosis of COVID-19 infection under section 564(b) (1) of the Act, 21 U.S.C. 360bbb-3(b) (1), unless the authorization is terminated or revoked.

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