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|-----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
|                                                                                                                                   |  | <b>Centers Laboratory Inc.</b><br> |                                                             | <b>Client Information</b><br><b>ACCOUNT:</b><br>Citadel Rehabilitation and Nursing Center at Kingsbridge<br>3400 Cannon Place<br>Bronx, NY 10463 |  |
| <b>Patient Information</b>                                                                                                        |  |                                                                                                                    | <b>Ordering Physician Information</b>                       |                                                                                                                                                  |  |
| <b>NAME:</b> Seda Freytes, Alicia                                                                                                 |  |                                                                                                                    | <b>PHYSICIAN NAME:</b> Talpada, Motibhai MD                 |                                                                                                                                                  |  |
| <b>D.O.B.:</b> 3/12/1945 <b>SEX:</b> Female                                                                                       |  |                                                                                                                    | <b>UPIN:</b>                                                |                                                                                                                                                  |  |
| <b>I.D.:</b> 7534 <b>S.S.N:</b> 101-36-9921                                                                                       |  |                                                                                                                    | <b>NPI:</b> 1134502958                                      |                                                                                                                                                  |  |
| <b>UNIT:</b> West 3 <b>ROOM/BED:</b> 321/P                                                                                        |  |                                                                                                                    | <b>DIAGNOSIS CODES</b>                                      |                                                                                                                                                  |  |
| <b>ORDER DATE/TIME:</b>                                                                                                           |  |                                                                                                                    | Z11.59                                                      |                                                                                                                                                  |  |
| <b>COLLECTION DATE/TIME:</b>                                                                                                      |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>FASTING:</b> Y / N                                                                                                             |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>Responsible Party</b>                                                                                                          |  |                                                                                                                    | <b>TEST LIST</b>                                            |                                                                                                                                                  |  |
| <b>NAME:</b> Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br><b>ADDRESS:</b> 3400 Cannon Place<br>Bronx, NY 10463 |  |                                                                                                                    | Nasopharyngeal swab for COVID19 ,A&B INFLUENZA ANTIGEN ,RSV |                                                                                                                                                  |  |
| <b>Primary Billing (INSURANCE)</b>                                                                                                |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>INS NAME:</b> Medicaid<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> XP21665X        |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>2nd Billing (INSURANCE)</b>                                                                                                    |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>INS NAME:</b> Unassigned<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> N/A           |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
|                                                                                                                                   |  | <b>INTERNAL CONTROL</b>                                                                                            |                                                             |                                                                                                                                                  |  |
| ____ L-Lav ____ Cultrt ____ R-Red ____ S-SST ____ GY-Grey ____ Lt. Blue ____ Black & Yellow Tube                                  |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| ____ G-Green ____ Y-Yellow ____ W-PPT ____ RB-Royal Blue ____ Strl Cup                                                            |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| ____ Viral Cul ____ O&P ____ BLD Cul ____ FS-Froz ____ Slide ____ Thinprep Vial                                                   |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| ____ Rand Urine Cup ____ 24 hr ____ U-Urn Tube ____ Timed ____ BORICULT                                                           |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>LAB I.D. #</b>                                                                                                                 |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |

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| <b>Patient Information</b>                                                                                                        |  |                                                                                                                    | <b>Ordering Physician Information</b>                       |                                                                                                                                                  |  |
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| <b>I.D.:</b> 7534 <b>S.S.N:</b> 101-36-9921                                                                                       |  |                                                                                                                    | <b>NPI:</b> 1134502958                                      |                                                                                                                                                  |  |
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| <b>ORDER DATE/TIME:</b>                                                                                                           |  |                                                                                                                    | Z11.59                                                      |                                                                                                                                                  |  |
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| <b>FASTING:</b> Y / N                                                                                                             |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
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| <b>NAME:</b> Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br><b>ADDRESS:</b> 3400 Cannon Place<br>Bronx, NY 10463 |  |                                                                                                                    | Nasopharyngeal swab for COVID19 ,A&B INFLUENZA ANTIGEN ,RSV |                                                                                                                                                  |  |
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| <b>2nd Billing (INSURANCE)</b>                                                                                                    |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
| <b>INS NAME:</b> Unassigned<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> N/A           |  |                                                                                                                    |                                                             |                                                                                                                                                  |  |
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