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|---------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
|                                                                                                                     |  | Centers Laboratory Inc.                                                          |                                                                | Client Information                                                                                                      |  |
|                                                                                                                     |  |  |                                                                | <b>ACCOUNT:</b><br>Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br>3400 Cannon Place<br>Bronx, NY 10463 |  |
|                                                                                                                     |  |                                                                                  |                                                                |                                                                                                                         |  |
| Patient Information                                                                                                 |  |                                                                                  | Ordering Physician Information                                 |                                                                                                                         |  |
| NAME: Green, Bennie                                                                                                 |  |                                                                                  | PHYSICIAN NAME: Talpada, Motibhai MD                           |                                                                                                                         |  |
| D.O.B.: 8/16/1939      SEX: Female                                                                                  |  |                                                                                  | UPIN:                                                          |                                                                                                                         |  |
| I.D.: 8208      S.S.N: 177-32-4877                                                                                  |  |                                                                                  | NPI: 1134502958                                                |                                                                                                                         |  |
| UNIT: West 5      ROOM/BED: 531/A                                                                                   |  |                                                                                  | DIAGNOSIS CODES                                                |                                                                                                                         |  |
| ORDER DATE/TIME:                                                                                                    |  |                                                                                  | Z01.89                                                         |                                                                                                                         |  |
| COLLECTION DATE/TIME:                                                                                               |  |                                                                                  | FASTING: Y / N                                                 |                                                                                                                         |  |
| Responsible Party                                                                                                   |  |                                                                                  | TEST LIST                                                      |                                                                                                                         |  |
| NAME: Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br>ADDRESS: 3400 Cannon Place<br>Bronx, NY 10463 |  |                                                                                  | NASOPHARYGEAL SWAB FOR COVID 19, INFLUENZA ANTIGEN A&B AND RSV |                                                                                                                         |  |
| Primary Billing (INSURANCE)                                                                                         |  |                                                                                  |                                                                |                                                                                                                         |  |
| INS NAME: Medicaid<br>PAYOR CODE:<br>GROUP #:<br>ADDRESS:<br>,<br>SUBSCRIBER#: PM57010A                             |  |                                                                                  |                                                                |                                                                                                                         |  |
| 2nd Billing (INSURANCE)                                                                                             |  |                                                                                  |                                                                |                                                                                                                         |  |
| INS NAME: Unassigned<br>PAYOR CODE:<br>GROUP #:<br>ADDRESS:<br>,<br>SUBSCRIBER#: N/A                                |  |                                                                                  |                                                                |                                                                                                                         |  |
|                                                                                                                     |  | INTERNAL CONTROL                                                                 |                                                                |                                                                                                                         |  |
| ____ 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                                             |  |                                                                                  |                                                                |                                                                                                                         |  |
| LAB I.D. #                                                                                                          |  |                                                                                  |                                                                |                                                                                                                         |  |

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|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
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| Patient Information                                                                                                               |  |                                                                                  | Ordering Physician Information                                 |                                                                                                                         |  |
| <b>NAME:</b> Green, Bennie                                                                                                        |  |                                                                                  | <b>PHYSICIAN NAME:</b> Talpada, Motibhai MD                    |                                                                                                                         |  |
| <b>D.O.B.:</b> 8/16/1939 <b>SEX:</b> Female                                                                                       |  |                                                                                  | <b>UPIN:</b>                                                   |                                                                                                                         |  |
| <b>I.D.:</b> 8208 <b>S.S.N:</b> 177-32-4877                                                                                       |  |                                                                                  | <b>NPI:</b> 1134502958                                         |                                                                                                                         |  |
| <b>UNIT:</b> West 5 <b>ROOM/BED:</b> 531/A                                                                                        |  |                                                                                  | <b>DIAGNOSIS CODES</b>                                         |                                                                                                                         |  |
| <b>ORDER DATE/TIME:</b>                                                                                                           |  |                                                                                  | Z01.89                                                         |                                                                                                                         |  |
| <b>COLLECTION DATE/TIME:</b>                                                                                                      |  |                                                                                  |                                                                |                                                                                                                         |  |
| <b>FASTING:</b> Y / N                                                                                                             |  |                                                                                  |                                                                |                                                                                                                         |  |
| Responsible Party                                                                                                                 |  |                                                                                  | TEST LIST                                                      |                                                                                                                         |  |
| <b>NAME:</b> Citadel Rehabilitation and Nursing Center at Kingsbridge<br><br><b>ADDRESS:</b> 3400 Cannon Place<br>Bronx, NY 10463 |  |                                                                                  | NASOPHARYGEAL SWAB FOR COVID 19, INFLUENZA ANTIGEN A&B AND RSV |                                                                                                                         |  |
| Primary Billing (INSURANCE)                                                                                                       |  |                                                                                  |                                                                |                                                                                                                         |  |
| <b>INS NAME:</b> Medicaid<br><b>PAYOR CODE:</b><br><b>GROUP #:</b><br><b>ADDRESS:</b><br>,<br><b>SUBSCRIBER#:</b> PM57010A        |  |                                                                                  |                                                                |                                                                                                                         |  |
| 2nd Billing (INSURANCE)                                                                                                           |  |                                                                                  |                                                                |                                                                                                                         |  |
| <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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| ____ 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                                                           |  |                                                                                  |                                                                |                                                                                                                         |  |
| LAB I.D. #                                                                                                                        |  |                                                                                  |                                                                |                                                                                                                         |  |