		Client Information
Attending: Silberberg, Charles MD	***CENTERS LABORATORY***	**ACCOUNT:** Citadel Rehabilitation and Nursing Center at Kingsbridge 3400 Cannon Place Bronx,NY 10463

Patient Information	**Ordering Physician Information**
NAME: Elguicze, Mary	**PHYSICIAN NAME:** Allen, Debora NP
D.O.B.: 5/18/1942 **SEX:** Female	**UPIN:**
I.D.: 889 **S.S.N:** 117-32-3831	**NPI:** 1285726208
UNIT: East 3 **ROOM/BED:** 304/A	**DIAGNOSIS CODES**
ORDER DATE/TIME:	Z29.9
COLLECTION DATE/TIME:	
	FASTING: Y / N
Responsible Party	**TEST LIST**
NAME: Citadel Rehabilitation and Nursing Center at Kingsbridge **ADDRESS:** 3400 Cannon Place Bronx, NY 10463	NASOPHARYNGEAL SWAB FOR COVID 19,Influenza A & B antigen and RSV
Primary Billing (INSURANCE)	
INS NAME: Medicaid **PAYOR CODE:** **GROUP #:** **ADDRESS:** , **SUBSCRIBER#:** ZZ81450X	
2nd Billing (INSURANCE)	
INS NAME: Evercare **PAYOR CODE:** **GROUP #:** **ADDRESS:** PO Box 31350 Sal Lake City, UT **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. #		

	CENTERS LABORATORY	**Client Information** **ACCOUNT:** Citadel Rehabilitation and Nursing Center at Kingsbridge 3400 Cannon Place Bronx,NY 10463

Patient Information	**Ordering Physician Information**
NAME: Elguicze, Mary	**PHYSICIAN NAME:** Allen, Debora NP
D.O.B.: 5/18/1942 **SEX:** Female	**UPIN:**
I.D.: 889 **S.S.N:** 117-32-3831	**NPI:** 1285726208
UNIT: East 3 **ROOM/BED:** 304/A	**DIAGNOSIS CODES**
ORDER DATE/TIME:	
COLLECTION DATE/TIME:	**FASTING: Y / N**
Responsible Party	**TEST LIST**
NAME: Citadel Rehabilitation and Nursing Center at Kingsbridge **ADDRESS:** 3400 Cannon Place Bronx, NY 10463	
Primary Billing (INSURANCE)	
INS NAME: Medicaid **PAYOR CODE:** **GROUP #:** **ADDRESS:** , **SUBSCRIBER#:** ZZ81450X	
2nd Billing (INSURANCE)	
INS NAME: Evercare **PAYOR CODE:** **GROUP #:** **ADDRESS:** PO Box 31350 Sal Lake City, UT **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. #		