State of Illinois

At-Home COVID Testing Program RFP

Appendix B

Please complete the form below for State of Illinois COVID-19 Testing Site

Please note that this site is not for obtaining testing from any testing site that is not run by State of Illinois. Please complete all information below as completely as possible for the patient you are requesting COVID-19 testing.

Personal Information

First Name

Last Name

Birthdate

MM/DD/YYYY

Language Preference

English

Pregnant

○ Yes ○ No ○ Unknown or Not Applicable

Race

Select Race

Ethnicity

Select Ethnicity

Sex

○ Male ○ Female

Street Address (Include apartment/suite number)

City

State

IL

Zip Code

Phone

Social Security Number (Optional)

Notification Email Address (Optional)

Symptom Onset Date

MM/DD/YYYY

Symptoms

- ☐ R05 Cough
- ☐ R50.9 Fever
- ☐ R06.02 Shortness of Breath
- ☐ Z20.828 Contact with and suspected exposure to viral communicable

Other Disease

Insurance Information

Insurance Status

○ Insurance ○ Medicaid ○ TRICARE ○ Medicare ○ None

Policy Holder Name

Relationship to Policy Holder (Self, Spouse, Other)

Member ID Number

Group ID

Insurance Provider

Insurance Begin Date

MM/DD/YYYY

Insurance End Date

MM/DD/YYYY

Insurance Company Phone Number (Optional)

Attestation

I, _____ attest that, on the date listed on this form, I am assisting the patient listed on this form in completing the COVID-19 testing form and applying for state or federal reimbursement for providing the test. I attest that, before starting my assistance, I asked the patient if I had their approval to gather this information for submission to the Illinois Department of Healthcare and Family Services and the patient verbally gave their approval.

☐ I Agree

Testing Site Information

Testing Site

Markham / 3824 W 159th Place

Submitter Information

Illinois Emergency Management Agency

Create New Requisition