

**CLIENT INFORMATION**

<b>Client Name:</b>			<b>Client Account #:</b> X _____		
<b>Contact Name:</b>			<b>Contact Phone #:</b>		
<b>Address (Street, City, State/Province, Zip Code, Country):</b>					
<b>Main Phone #:</b>	<b>Time Zone:</b>	<b>Volume Estimate:</b>	<b>Requested Go Live Date:</b> _____		
(Once the form has been completed, verified by client and Viracor Sales, and submitted; Viracor will provide the official go live date - which will be a minimum of 14-21 days from submission and starting on a Monday. Interface build requires client engagement and may require more time)					
<b>Sample Archive:</b>	Discard after 30 days	Long term storage (fee included)	<b>Ordering Method:</b>	Retriever	Interface
				Transition to Interface	

**TESTING SET UP (If more than 2 panels are needed, complete a separate form.)**

Test Name	Test Code	Ref Code	CPT Code <sup>1</sup>	Panel 1	Panel 2
ABO/Rh, Blood Type <sup>††</sup>	30832	14	86900, 86901		
Chagas (T. cruzi) EIA <sup>††</sup>	30824	3588	86753		
Chlamydia trachomatis, Neisseria gonorrhoeae (CT/GC) NAT <sup>††</sup>	30964	3674	87491, 87591		
Cytomegalovirus (CMV) Total Antibody EIA (Capture - CMV) <sup>††</sup>	30809	3502	86403		
Cytomegalovirus (CMV) IgG EIA*	30811	3504	86644		
Cytomegalovirus (CMV) IgM EIA*	30812	3505	86645		
Epstein-Barr Virus (EBV) IgG EIA*	30813	3513	86665		
Epstein-Barr Virus (EBV) IgM EIA*	30814	3514	86665		
Hepatitis B Surface Antigen (HBsAg) EIA <sup>††</sup>	30815	3214	87340		
Hepatitis B Core Total (HBc Total) Antibody EIA <sup>††</sup>	30821	3211	86704		
Hepatitis C Virus Antibody (HCV Ab) EIA <sup>††</sup>	30823	3221	86803		
HIV-1/HIV-2 Plus O EIA <sup>††</sup>	30816	3521	86703		
Human T-Lymphotropic Virus (HTLV) I/III EIA <sup>††</sup>	30818	3546	86687, 86688		
RBC Antibody (Ab) Screen*	30833	94	86850		
Strongyloides Antibody IgG EIA*	30826	2739	86682		
Syphilis Screening, Nontreponemal (RPR) <sup>††</sup>	30806	3551	86592		
Syphilis (T. pallidum) Captia-G IgG Antibody EIA <sup>††</sup>	30808	325	86592		
Toxoplasma (Toxo) IgG EIA*	30827	3535	86777		
Toxoplasma (Toxo) IgM EIA*	30828	3820	86778		
Ul trio Elite HIV-1/2, HCV, HBV NAT <sup>††</sup> (auto-reflex to discriminatory)	30805	2770	87516, 87521, 87535		
West Nile Virus (WNV) NAT <sup>††</sup>	30825	2722	87797		

**REFLEX REQUIREMENTS (Reflex requirements must be the same for each panel)**

Reflex Test Name	Test Code	Ref Code	CPT Code <sup>1</sup>	Reflex	Reflex from Test Code
Anti-Hepatitis B Core IgM	33039	3212	86705		3211
Chagas ESA Confirmatory	33040	194	86753		3588
Cytomegalovirus (CMV) IgG EIA*	30811	3504	86644		
Cytomegalovirus (CMV) IgM EIA*	30812	3505	86645		
Hepatitis B Surface Antigen (HBsAg) Confirmatory EIA <sup>††</sup> (Reflex from HBsAg, test code 30815)	30829	3215	87341		30815
Hepatitis C Virus (HCV) Confirmatory LIA* (Reflex from HCV Ab, test code 30823)	30831	1012	86804		30823
HIV-1 Western Blot* (Reflex from HIV-1/2 Plus O, test code 30816)	30817	3522	86689		30816
Human T-Lymphotropic Virus (HTLV) I/III Immunoblot Confirmation* (Reflex from HTLV I/III, test code 30818)	30835	3540	86790		30818
Syphilis (T. pallidum) Captia-G IgG Antibody Confirmatory EIA <sup>††</sup>	30956	326	86592		

<sup>1</sup>The CPT codes provided are based on VRL Eurofins' interpretation of the American Medical Association's Current Procedural Terminology (CPT) codes and are provided for informational purposes only. CPT coding is the sole responsibility of the billing party. Questions regarding coding should be addressed to your local Medicare carrier.

\*NY Approved    †FDA Approved

<b>Client Approval:</b> Initial: _____ Name: _____ Date: _____	I verify the test information provided above is accurate and complete.
<b>Sales Representative Name:</b> _____	Phone #: _____ Email: _____

**INTERNAL USE ONLY**

Panel	Profile Name	Test Code	Ref Code	Tube Type	Specimen Collection / Shipping Instructions	Panel List Price	Panel TOS Code
Panel 1				Red Top - Serum (Qty. ____) Purple - Plasma (Qty. ____) APTIMA Urine Specimen Transport (Qty. ____)			
Panel 2				Red Top - Serum (Qty. ____) Purple - Plasma (Qty. ____) APTIMA Urine Specimen Transport (Qty. ____)			

<b>VRL Approval:</b> Initial: _____ Name: _____ Date: _____	I verify the test information provided above is accurate and complete.
<b>Viracor Final Approval:</b> Name: _____	Date: _____ Email: _____

Once this form is complete, attach and submit a request to the !US42\_DL-VRL-Viracor-AcctSetup@Eurofins-Viracor.com email address to start the Pre-Transplant account setup, copying your manager.