COVID–19 Test Authorization Form

Company Name:	
Patient’s Name:	
Date of Birth:	
Date of Service:	

I ____________________________________ authorize UrgentMED and its affiliates to bill the above named account for:

☐ Quidel Sofia Antigen Test / Carestart COVID-19 Antigen Test ($95.00) or an equivocal antigen test that is under FDA Emergency Use Authorization.

☐ PCR (Polymerase Chain Reaction) COVID – 19 Diagnostic Testing ($150.00)