

CLIENT INFORMATION

ORDERING PHYSICIAN	NPI#
REFERRING PHYSICIAN	Fax copy of report to: () -

All diagnoses should be provided by the ordering physician or his or her authorized designee. Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

REQUIRED	ICD-CM	ICD-CM
ICD-CM	ICD-CM	ICD-CM

CLINICAL INFORMATION

Collection Date: _____ Time: A.M. P.M. Hours Fixed: _____
 Number of Jars: _____ Fixative: 10% Neutral Buffered Formalin Other: _____
 Rule out Lymphoma Rule out H. pylori Rule out other: _____

SPECIMEN TYPE

Bladder GI Lower Liver Skin
 Breast GI Upper Lymph Node Vas Deferens (Sterilization)
 Culture GYN Prostate Other: _____

MICROBIOLOGY*

Current Antibiotic Therapy: _____
 008649 Aerobic Culture Site _____
 008003 Anaerobic and Aerobic Culture Site _____
 183111 Anaerobic and Aerobic Culture with Gram Stain Site _____
 008482 Fungus (Mycology) Culture Site _____
 Other: _____ Site _____

HISTOLOGY

Histology (gross and microscopic) Histology Technical Component
 Breast Histology, if malignant reflex to ER, PR, HER2 by IHC, reflex to HER2/CEP17 FISH if 2+ by IHC⁺
 Consultation _____ (Send pathology report)
 Separately billable stains may be added by pathologist when medically necessary to render a diagnosis.

ADDITIONAL TESTS

ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC HER2 by IHC, reflex to HER2/CEP17 FISH if 2+ by IHC⁺
 HER2/CEP17 FISH Flow Cytometry (tissue/fluids)*
 Prosigna® Breast Cancer Prognostic Gene Signature Assay@
REQUIRED: Gross Tumor Size ≤ 2 cm > 2 cm
REQUIRED: Nodal Status Negative 1-3 Nodes
 Other: _____
 Stone Analysis, Urinary Tract Calculus
 Specimen Obtained: Surgically Removed Lithotripsy Spontaneously Passed
 Specimen Type: Bladder Kidney Other: _____

CYTOLOGY

FNA Site: _____ Fluids Type: _____
 Brushing Type: _____ Washing Type: _____
 Other: _____

PATIENT INFORMATION

Name (LAST, FIRST, MIDDLE) _____
 Address _____
 City, State, Zip _____
 Date of Birth: _____ Sex M F
 Phone Number _____ Race: _____
 MRN / PATIENT ID# _____ CHART# _____

BILLING INFORMATION (face sheet & front and back of insurance card must be attached)

Bill: My Account Insurance Medicare Medicaid Patient Workers Comp
Patient Status: Hospital Inpatient Hospital Outpatient Non-Hospital Patient
Insurance Information: See attached
Insured Information: Name _____
 Relationship to Patient (circle one) Self Spouse Child Other:
Primary Insurance Co: _____ Authorization # _____
 Billing Address _____ Insured # _____
 Billing City, State, Zip _____ Group # _____
Secondary Insurance Co: _____ Authorization # _____
 Billing Address _____ Insured # _____
 Billing City, State, Zip _____ Group # _____

SPECIMEN INFORMATION

Specimen #	Body Site/Descriptor	Biopsy Method (excision, punch, shave, core, incisional, FNA)	Clinical Data (Endoscopic Findings if applicable)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

When ordering tests for which Medicare or Medicaid reimbursements will be sought, physicians should order only those tests that are medically necessary for the diagnosis or treatment of the patient.

PHYSICIAN / AUTHORIZED SIGNATURE: _____

Patient, Client and Billing Information is requested for timely processing of this case. Medicare and other third party payors require that services be medically necessary for coverage, and generally do not cover routine screening tests.
 Refer to Determining Necessity of ABN Completion on Reverse
 @ = Subject to Medicare medical necessity guidelines

SPECIMEN LABEL INSTRUCTIONS:

- 1.) Complete the requisition with all requested information.
- 2.) Remove the required number of labels from the front of this sheet.
- 3.) Place one (1) label on each specimen container (not on the lid).

PLEASE DISPOSE OF UNUSED LABELS.

Name: _____ Name: _____ Name: _____ Name: _____
 Name: _____ Name: _____ Name: _____ Name: _____
 Name: _____ Name: _____ Name: _____ Name: _____

Item# 079543 1192 Ambulatory Surgery Center

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Test Combination/Panel Policy

LabCorp's policy is to provide physicians, in each instance, with the flexibility to choose appropriate tests to assure that the convenience of ordering test combinations/panels does not distance physicians who wish to order a test combination/profile from making deliberate decisions regarding which tests are truly medically necessary. All the tests offered in test combinations/panels may be ordered individually using the LabCorp request form. LabCorp encourages clients to contact their local LabCorp representative or LabCorp location if the testing configurations shown here do not meet individual needs for any reason, or if some other combination of procedures is desired.

In an effort to keep our clients fully informed of the content, charges and coding of its test combinations/panels when billed to Medicare, we periodically send notices concerning customized test combinations/panels, as well as information regarding patient fees for all LabCorp services. We also welcome the opportunity to provide, on request, additional information in connection with our testing services and the manner in which they are billed to physicians, health care plans, and patients.

The CPT code(s) listed are in accordance with the current edition of *Current Procedural Terminology*, a publication of the American Medical Association. CPT codes are provided for the convenience of our clients; however, correct coding often varies from one carrier to another. Consequently, the codes presented here are intended as general guidelines and should not be used without confirming with the applicable payor that their use is appropriate in each case. All laboratory procedures will be billed to third-party carriers (including Medicare and Medicaid) at fees billed to patients and in accordance with the specific CPT coding required by the carrier. Microbiology CPT code(s) for additional procedures such as susceptibility testing, identification, serotyping, etc. will be billed in addition to the primary codes when appropriate. LabCorp will process the specimen for a Microbiology test based on source.

Aerobic Culture*	87070
Anaerobic Culture*	87075
Fungus (Mycology) Culture*	87101 (may vary with source)
Gram Stain	87205
ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC	88360 x2
HER2 by IHC	88360
HER2/CEP17 FISH	88377
Prosigna® Breast Cancer Prognostic Gene Signature Assay	@ 81520, 88381
Stone Analysis - Urinary Tract Calculus	82365 (FTIR) or 82355

Flow Cytometry Tissue/fluids panel (19)*⊕ antibodies

CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11c, CD13 or CD33, CD19, CD20, CD22, CD23, CD38, CD45, CD56, CD71, kappa light chain, lambda light chain

@ Subject to Medicare medical necessity guidelines

* Additional antibodies may be added if determined to be medically necessary to render a diagnosis in the opinion of the reviewing pathologist

⊕ Markers performed determined by testing facility

* ID and Susceptibility at additional charges per organism if indicated

⊕ Wolff, Antonio C. et al. Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer: American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Focused Update. *J Clin Oncol* 36:2105-2122. 2018
PMID: 29846122

Determining Necessity of Advance Beneficiary Notice of Non-coverage (ABN) Completion*

1. **Diagnose.** Determine your patient's diagnosis.
2. **Document.** Write the diagnosis code(s) on the front of this requisition.
3. **Verify.** Determine if the laboratory test(s) ordered for the patient is subject to Local Coverage Determination or National Coverage Determination. This information can be located in the policies published by your Medicare Administrative Contractor (MAC), CMS, or www.LabCorp.com/MedicareMedicalNecessity.
4. **Review.** If the diagnosis code for your patient **does not** meet the medical necessity requirements set forth by Medicare or the test(s) is being performed more frequently than Medicare allows, an ABN should be completed.

*An ABN should be completed for all tests that are considered investigational (experimental or for research use) by Medicare.

How to Complete an Advance Beneficiary Notice of Non-coverage (ABN)

Medicare is very specific in requiring that all of the information included on the ABN be completed. Additionally, LabCorp requests that the specimen number or bar code label be included on the form. To be valid an ABN must:

1. Be executed on the CMS approved ABN form (CMS-R-131)
2. Identify the Medicare Part B Beneficiary, using the name as it appears on the patient's red, white and blue Medicare card
3. Indicate the test(s)/procedure(s) which may be denied within the relevant reason column
4. Include an estimated cost for the test(s)/procedure(s) subject to the ABN
5. Have 'Option 1', 'Option 2', or 'Option 3' designated by the beneficiary
6. Be signed **and** dated by the beneficiary or his/her representative **prior to** the service being rendered

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