

ACCOUNT INFORMATION

ACCOUNT NO. _____ TELEPHONE NO. _____

ACCOUNT NAME AND ADDRESS _____

REQUESTING PHYSICIAN (PLEASE PRINT) _____ PHYSICIAN/AUTHORIZED SIGNATURE _____

REQUESTING PHYSICIAN NPI _____ REFERRING PHYSICIAN (PLEASE PRINT) _____

PATIENT INFORMATION

CHART NUMBER _____ PATIENT D.O.B. _____

PATIENT LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SEX M F

RACE _____ MRN / PATIENT ID# _____ PATIENT TELEPHONE NO. _____

BILLING INFORMATION

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required) _____

REQUIRED ICD-CM CODE(S): _____

BILL: PRACTICE/FACILITY PATIENT MEDICARE MEDICAID INSURANCE REFERRAL # _____

POLICY/ID# _____ GROUP # _____ 2ND INS POLICY/ID# _____ GROUP # _____

INSURANCE CARRIER _____ INSURANCE CARRIER _____

CLAIM ADDRESS _____ CLAIM ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

PATIENT HOSPITAL STATUS INPATIENT OUTPATIENT NON-PATIENT

INSURED'S NAME _____ INSURED'S DOB _____

PATIENT'S RELATIONSHIP TO INSURED: SPOUSE CHILD OTHER _____

SPECIMEN COLLECTION

METHOD/SPECIMEN BIOPSY WASHING BRUSHING POLYPECTOMY OTHER _____ COLLECTION DATE: ____/____/____

ENDOSCOPIC CODES

Please write the applicable number(s) for each corresponding biopsy specimen in the appropriate section below. DO NOT CIRCLE CODE NUMBERS.

1 EROSION	4 MASS	7 POLYP	10 STRICTURE	13 HIATAL HERNIA
2 ERYTHEMA	5 NODULARITY	8 POLYPOSIS	11 ULCER	14 OTHER _____
3 GRANULARITY	6 NORMAL	9 PSEUDOMEMBRANE	12 BARRETT'S MUCOSA	

UPPER GI

CLINICAL DATA (Check all that apply)

BLEEDING _____ ANOREXIA REFLUX
 DYSPHAGIA NAUSEA WEIGHT LOSS
 HEARTBURN NSAID USAGE DYSPEPSIA
 HEME POSITIVE STOOL DIARRHEA
 PAIN _____
 IRON DEFICIENT ANEMIA
 PERSONAL HISTORY OF CANCER _____
 PERSONAL HISTORY OF LYMPHOMA
 HISTORY OF *H. pylori*
 HISTORY OF BARRETT'S ESOPHAGUS
 Other: _____

SPECIAL INDICATIONS

Rule Out Barrett's Esophagus Rule Out Fungi
 Rule Out Dysplasia Rule Out Viral Inclusions
 Rule Out *H. pylori* Rule Out Reflux Esophagitis
 Rule Out Celiac Disease Rule Out Eosinophilic Esophagitis
 Rule Out Giardia
 Other: _____

OTHER TESTS (see reverse for CPT Codes Billed)

180836 *H. pylori* Urea Breath Test 1-hour Fast? Yes No
 180764 *H. pylori* Stool Antigen
 511345 Hereditary Hemochromatosis, DNA Analysis
 550123 HCV FibroSURE®@%
 550140 NASH FibroSURE®@%*
 550180 ASH FibroSURE®@%*
 * Required for ASH/NASH:
 Fasting at least 8 hours? Yes No Height _____ (ins) Weight _____ (lbs)
 Other: _____

UPPER GI TEST REQUEST †

HISTOLOGY (Gross & Microscopic)
 CYTOLOGY
 CONSULTATION: On referred slides (Send pathology report)
 CONSULTATION: On referred material requiring slide prep (Send pathology report)
 † Separately billable stains may be added by pathologist when medically necessary to render a diagnosis.

ESOPHAGUS

SPECIMEN #	From	TYPE				BODY SITE/ DESCRIPTOR				ENDOSCOPIC FINDINGS (See codes above)
		BIOPSY	BRUSHING	WASHING	OTHER	Eso Prox.	Eso Mid	Eso Distal	E.C. Junct.	
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

STOMACH / DUODENUM

SPECIMEN #	From	TYPE				BODY SITE/ DESCRIPTOR				ENDOSCOPIC FINDINGS (See codes above)	
		BIOPSY	BRUSHING	WASHING	OTHER	Cardia	Fundus/Body	Antral-Body Transition	Antrum		Duodenum (Bulb)
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

LOWER GI

CLINICAL DATA (Check all that apply)

BLEEDING _____ FAMILY HISTORY OF CANCER (TYPE) _____
 DIARRHEA (BLOODY) PERSONAL HISTORY OF CANCER (TYPE) _____
 DIARRHEA (WATERY) PERSONAL HISTORY OF COLON POLYPS
 WEIGHT LOSS PERSONAL HISTORY OF IDIOPATHIC INFLAMMATORY BOWEL DISEASE
 PAIN _____
 HEME POSITIVE STOOL

SPECIAL INDICATIONS

COLITIS SURVEILLANCE COLONOSCOPY RULE OUT IDIOPATHIC INFLAMMATORY BOWEL DISEASE
 POLYP/NEOPLASM SURVEILLANCE COLONOSCOPY RULE OUT CROHN'S
 RULE OUT VIRAL INCLUSIONS RULE OUT ULCERATIVE COLITIS
 RULE OUT PARASITES RULE OUT DYSPLASIA
 RULE OUT MICROSCOPIC COLITIS RULE OUT MALIGNANCY
 OTHER: _____

BIOPSY/EXCISION DATA

ANAL FISSURE
 ANAL FISTULA
 ANAL TAG
 APPENDECTOMY (NON-INCIDENTAL)
 CHOLECYSTECTOMY
 HEMORRHOIDS
 LIVER BIOPSY

OTHER TESTS

LOWER GI TEST REQUEST †

HISTOLOGY (Gross & Microscopic)
 CYTOLOGY – BRUSHING
 CYTOLOGY – WASHING
 CYTOLOGY – OTHER _____
 CONSULTATION: On referred slides (Send pathology report)
 CONSULTATION: On referred material requiring slide prep (Send pathology report)
 Histology† (Gross & Microscopic Exam) with Reflex to Lynch Syndrome Comprehensive Tumor Evaluation* if meets Revised Bethesda criteria ♦
 Histology† (Gross & Microscopic Exam) with Reflex to Lynch Syndrome Comprehensive Tumor Evaluation* if carcinoma or tubular adenoma at <40
 *Includes MLH1/MSH2/MSH6/PMS2 by IHC and/or MSI by PCR. If MLH1 is deficient, reflex to BRAF Gene Mutation; if negative, reflex to MLH1 Promoter Methylation#

SPECIMEN #	From	BODY SITE											DESCRIPTOR			ENDOSCOPIC FINDINGS (See codes above)	
		Ileum	Ileocecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Anastomosis	Proximal	Mid	Distal		
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Site _____	Jan 1	Site _____	Jan 5	Site _____	Jan 9	Site _____	Jan 13	Site _____	Jan 17	Site _____	Jan 21
Name _____	Jan 2	Name _____	Jan 6	Name _____	Jan 10	Name _____	Jan 14	Name _____	Jan 18	Name _____	Jan 22
Site _____	Jan 3	Site _____	Jan 7	Site _____	Jan 11	Site _____	Jan 15	Site _____	Jan 19	Site _____	Jan 23
Name _____	Jan 4	Name _____	Jan 8	Name _____	Jan 12	Name _____	Jan 16	Name _____	Jan 20	Name _____	Jan 24
Site _____		Site _____		Site _____		Site _____		Site _____		Site _____	
Name _____		Name _____		Name _____		Name _____		Name _____		Name _____	

Labeling Instructions

- Complete all requested information on requisition form.
- Place the indicated label on the corresponding specimen jar. Use one label per specimen.
- Discard all unused labels.**

For Questions, Contact Client Services at 1-800-328-2666.

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Refer to Determining Necessity of ABN Completion on reverse.
 @ = Subject to Medicare medical necessity guidelines
 % = Subject to Medicare frequency guidelines
 # = Medicare deems investigational

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

Lynch Syndrome Eval performed/billed by Labcorp's Integrated Oncology division.

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.

H. pylori Urea Breath Test CPT Code: 83013			Test No. 180836			H. pylori Stool Antigen CPT Code: 87338			Test No. 180764		
HCV FibroSURE® CPT Codes: 81596			Test No. 550123			Hereditary Hemochromatosis, DNA Analysis CPT Code: 81256			Test No. 511345		
When ordered Individually use Test No.			Components			CPT Code(s)					
122135			Alpha-2 Macroglobulin			83883					
001628			Haptoglobin			83010					
016873			Apolipoprotein A-1			82172					
001099			Bilirubin, Total			82247					
001958			GGT %@			82977					
001545			ALT (SGPT)			84460					
NASH FibroSURE® CPT Codes: 83883, 83010, 82172, 82247, 82977, 84460, 82465, 84478, 82947, 84450			Test No. 550140			ASH FibroSURE® CPT Codes: 83883, 83010, 82172, 82247, 82977, 84460, 82465, 84478, 82947, 84450			Test No. 550180		
When ordered Individually use Test No.			Components			CPT Code(s)			When ordered Individually use Test No.		
122135			Alpha-2 Macroglobulin			83883			122135		
001628			Haptoglobin			83010			001628		
016873			Apolipoprotein A-1			82172			016873		
001099			Bilirubin, Total			82247			001099		
001958			GGT %@			82977			001958		
001545			ALT (SGPT)			84460			001545		
001065			Cholesterol, Total %@			82465			001065		
001172			Triglycerides %@			84478			001172		
001032			Glucose %@			82947			001032		
001123			AST (SGOT)			84450			001123		

- ◆ Revised Bethesda guidelines for testing colorectal tumors for MSI: Colorectal cancer diagnosed in a patient who is <50 years of age, or Colorectal cancer with the MSI-H histology diagnosed in a patient who is <60 years of age.

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

Symbols used to designate Medicare medical review as of 04/01/2021

- @ = Subject to Medicare medical necessity guidelines
- % = Subject to Medicare frequency guidelines
- # = Medicare deems investigational. Medicare does not pay for services it deems investigational.

