Dianon PATHOLOGY

LabCorp Specialty Testing Group
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BREAST PATHOLOGY

CLIENT INFORMATION

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

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 Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-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 TYPE/INFORMATION

☐ Palpable ☐ Non-palpable #1 Clock Face _____ Distance _____
☐ Suspicious ☐ Non-suspicious #2 Clock Face _____ Distance _____
☐ Family History ☐ Microcalcifications #3 Clock Face _____ Distance _____
#4 Clock Face _____ Distance _____

Collection Method

☐ Core Needle ☐ Incisional ☐ Excisional/Lumpectomy ☐ Nipple Smear
☐ Vacuum-Assisted ☐ Sentinel Node ☐ Fine Needle Aspiration ☐ Lymph Node

Body Site/Location

☐ Left ☐ Right ☐ Upper ☐ Lower
☐ Inner ☐ Outer ☐ Central Portion ☐ Nipple/Areola
☐ Axillary Tail ☐ Other:

Paraffin Block Site: Number of blocks:

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 policies published by your Medicare Administrative Contractor (MAC), CMS, or www.Labcorp.com/MedicareMedicalNecessity when ordering tests that are subject to ABN guidelines.

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

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.

CLINICAL/SPECIMEN INFORMATION

Collection Date: Time: ☐ A.M. ☐ P.M. No. of Jars

Fixative: ☐ 10% Neutral Buffered Formalin ☐ Other (Specify):

Time to Fixation (Cold Ischemic Time): (minutes/seconds)

☐ MRI ☐ Ultrasound ☐ Stereotactic

Previous Cancer and/or any other relevant Case History:

Narrative Diagnosis/Clinical Data/Signs & Symptoms:

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)

ICD-CM		ICD-CM		ICD-CM		ICD-CM	

HISTOLOGY (Gross and Microscopic Exam)

☐ Breast Histology

☐ Breast Histology; if malignant reflex to **ER, PR, HER2 by IHC;** reflex to **HER2/CEP17 FISH** if 2+ by IHC+

Separately billable stains may be added by pathologist when medically necessary to render a diagnosis.

PROGNOSTIC TISSUE TESTING (Malignant samples only)

☐ ER, PR, HER2 by IHC, reflex to HER2/CEP17 FISH if 2+ by IHC+
☐ ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC
☐ MIB Ki-67 by IHC
☐ p53 Tumor Suppressor Gene# by IHC
☐ Flow Cytometry*@
☐ PIK3CA Mutation Analysis, Breast Cancer
☐ Prosigna® Breast Cancer Prognostic Gene Signature Assay@
Required: Gross Tumor Size ☐ ≤ 2 cm ☐ > 2 cm
Required: Nodal Status ☐ Negative ☐ 1-3 Nodes

Other:_____

HER2 TISSUE ANALYSIS+

☐ HER2 by IHC, reflex to HER2/CEP17 FISH if 2+ by IHC
☐ HER2/CEP17 FISH

CYTOLOGY

☐ FNA Site: _____ ☐ Fluids Type: _____
☐ Other:

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.

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Name: _____ **Name:** _____

Name: _____ **Name:** _____

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.

B-1A

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.

ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC	88360x2
MIB Ki-67 by IHC	88360
p53 Tumor Suppressor Gene by IHC	88360#
HER2 by IHC	88360
HER2/CEP17 by FISH	88377
Flow Cytometry Breast or Lymph Node	88184@, 88185x18@, 88189@
PIK3CA Mutation Analysis, Breast Cancer	81404, 88381
Prosigna® Breast Cancer Prognostic Gene Signature Assay	81520, 88381

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

✢ 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

★ 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

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