

CLIENT INFORMATION

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

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: _____

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

© 2021 Laboratory Corporation of America® Holdings. All rights reserved.

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.

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, IVD
 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.

Dianon Systems, Inc. is a subsidiary of Laboratory Corporation of America Holdings, using the brand Labcorp. 1437 REV 11/05/2021 CL 0356

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.

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, IVD	0155U, 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

Prosigna[®] is a registered trademark of NanoString Technologies, Inc.

labcorp