

ACCOUNT INFORMATION

ACCOUNT NO. _____ TELEPHONE NO. _____

ACCOUNT NAME AND ADDRESS _____

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

REQUESTING PHYSICIAN NPI _____ REFERRING PHYSICIAN _____

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) _____

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

REQUIRED ICD-CM CODE(S): _____

CLINICAL DATA (Check all that apply)

Bleeding _____ Family history of cancer _____

Diarrhea (bloody) _____ (type) _____

Diarrhea (watery) _____ Personal history of cancer _____

Weight loss _____ (type) _____

Pain _____ Personal history of Colon polyps _____

Heme positive stool _____ Personal history of idiopathic inflammatory bowel disease _____

ENDOSCOPIC CODES

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

1 Erosion	6 Normal	11 Stricture
2 Erythema	7 Polyp	12 Ulcer
3 Granularity	8 Polyposis	
4 Mass	9 Pseudomembrane	
5 Nodularity	10 Other _____	

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

Other: _____ Rule out malignancy

SPECIMEN COLLECTION

COLLECTION DATE: ____/____/____

Biopsy Brushing Polypectomy

Washing Other: _____

LYNCH SYNDROME

HISTOLOGY† (Gross & Microscopic Exam) with Reflex to Lynch Syndrome Tumor Evaluation* if colorectal carcinoma (any age) or tubular adenoma (<40 years old)

*Includes MLH1/MSH2/MSH6/PMS2 by IHC. If MLH1 is deficient, reflex to BRAF Gene Mutation; if negative, reflex to MLH1 Promoter Methylation

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

BIOPSY DATA

HISTOLOGY† (Gross and Microscopic Examination)

Consultation† Referred slides (**Send pathology report**)

Consultation† Referred material requiring slide prep (**Send pathology report**)

SPECIMEN #	From	BODY SITE (Check only one)										DESCRIPTOR (Check only one)			ENDOSCOPIC FINDINGS (See codes above)	
		Ileum	Ileo Cecal 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"/>	_____
_____	_____ 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"/>	_____
_____	_____ 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"/>	_____
_____	_____ 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"/>	_____
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_____	_____ 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"/>	_____

CYTOLOGY DATA

SPECIMEN #	From	BODY SITE (Check only one)										DESCRIPTOR (Check only one)			ENDOSCOPIC FINDINGS (See codes above)	
		Ileum	Ileo Cecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	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"/>	_____
_____	_____ 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"/>	_____
_____	_____ 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"/>	_____

OTHER TESTS

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

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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.

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 10/01/2024

@ = Subject to Medicare medical necessity guidelines.

% = Subject to Medicare frequency guidelines.

= Medicare deems investigational. Medicare does not pay for services it deems investigational.

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