

## LabCorp Specialty Testing Group

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### CLIENT INFORMATION

REQUESTING PHYSICIAN	NPI#
REFERRING PHYSICIAN	NPI#

### CLINICAL/SPECIMEN INFORMATION

Collection Date: \_\_\_\_\_ Number of Containers: \_\_\_\_\_  
 Fixative:  10% Neutral Buffered Formalin  Other (Specify): \_\_\_\_\_  
 Time to Fixation:  AM  PM Hours fixed: \_\_\_\_\_  
 MRI  Ultrasound  Stereotactic

Previous Cancer and/or any other relevant Case History:

Narrative Diagnosis/Clinical Data/Signs & Symptoms:

### 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

<input type="checkbox"/> Palpable	<input type="checkbox"/> Non-palpable	#1 Clock Face _____	Distance _____
<input type="checkbox"/> Suspicious	<input type="checkbox"/> Non-suspicious	#2 Clock Face _____	Distance _____
<input type="checkbox"/> Family History	<input type="checkbox"/> 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

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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<sup>+</sup>

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<sup>+</sup>  
 480277 ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC  
 481051 MIB Ki-67 by IHC  
 481044 p53 Tumor Suppressor Gene# by IHC  
 XL3 Flow Cytometry\*<sup>@</sup>  
 485113 PIK3CA Mutation Analysis, Breast Cancer  
 481210 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<sup>+</sup>

- 483289 HER2 by IHC, reflex to HER2/CEP17 FISH if 2+ by IHC  
 483248 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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1437 REV 10/13/2020 CL 0356

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Item# 0077677 Form# 1437 Breast Requisition

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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.

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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