Dianon PATHOLOGY
LabCorp Specialty Testing Group

1 Forest Parkway
Shelton, CT 06484
800-328-2666
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AMBULATORY SURGERY CENTER REQUISITION

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 Status: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital 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 #

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)

REQUIRED	ICD-CM		ICD-CM		ICD-CM	
ICD-CM		ICD-CM		ICD-CM		

CLINICAL INFORMATION

Collection Date: Time: ☐ A.M. ☐ P.M. Hours Fixed: _____

Number of Jars: _____ Fixative: ☐ 10% Neutral Buffered Formalin ☐ Other: _____

☐ Rule out Lymphoma ☐ Rule out H. *pylori* ☐ Rule out other: _____

SPECIMEN TYPE

☐ Bladder ☐ GI Lower ☐ Liver ☐ Skin

☐ Breast ☐ GI Upper ☐ Lymph Node ☐ Vas Deferens (Sterilization)

☐ Culture ☐ GYN ☐ Prostate ☐ Other: _____

MICROBIOLOGY*

Current Antibiotic Therapy: _____

☐ 008649 Aerobic Culture Site _____

☐ 008003 Anaerobic and Aerobic Culture Site _____

☐ 183111 Anaerobic and Aerobic Culture with Gram Stain Site _____

☐ 008482 Fungus (Mycology) Culture Site _____

☐ Other: _____ Site _____

HISTOLOGY

☐ Histology (gross and microscopic) ☐ Histology Technical Component

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

☐ Consultation _____ (Send pathology report)

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

ADDITIONAL TESTS

☐ ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC

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

☐ HER2/CEP17 FISH

☐ HERmark® Breast Cancer Assay

☐ XL3 Flow Cytometry (tissue/fluids)@✶

☐ Prosigna® Breast Cancer Prognostic Gene Signature Assay@

REQUIRED: Gross Tumor Size ☐ ≤ 2 cm ☐ > 2 cm

REQUIRED: Nodal Status ☐ Negative ☐ 1-3 Nodes

☐ Other: _____

☐ Stone Analysis, Urinary Tract Calculus

Specimen Obtained: ☐ Surgically Removed ☐ Lithotripsy ☐ Spontaneously Passed

Specimen Type: ☐ Bladder ☐ Kidney ☐ Other: _____

CYTOLOGY

☐ FNA Site: _____ ☐ Fluids Type: _____

☐ Brushing Type: _____ ☐ Washing Type: _____

☐ Other:

SPECIMEN INFORMATION

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.

Specimen #	Body Site/Descriptor	Biopsy Method (excision, punch, shave, core, incisional, FNA)	Clinical Data (Endoscopic Findings if applicable)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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 Determining Necessity of ABN Completion on Reverse
@ = Subject to Medicare medical necessity guidelines

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.

Name: _____ Name: _____ Name: _____ Name: _____

Name: _____ Name: _____ Name: _____ Name: _____

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.

B-1A

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.

Aerobic Culture*	87070
Anaerobic Culture*	87075
Fungus (Mycology) Culture*	87101 (may vary with source)
Gram Stain	87205
ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC	88360 x2
HER2 by IHC	88360
HER2/CEP17 FISH	88377
Prosigna® Breast Cancer Prognostic Gene Signature Assay	@ 81520, 88381
Stone Analysis - Urinary Tract Calculus	82365 (FTIR) or 82355

Flow Cytometry Tissue/fluids panel (19)*⌖ antibodies
CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11b or CD11c, CD19, CD20, CD23, CD30 or CD33, CD38, CD45, CD56, CD103 or FMC-7, HLA-DR, kappa light chain, lambda light chain

@ Subject to Medicare medical necessity guidelines
* 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
* ID and Susceptibility at additional charges per organism if indicated
✢ 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

Determining Necessity of Advance Beneficiary Notice of Noncoverage (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 Noncoverage (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

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