

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

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

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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⁺
 Breast Histology; if malignant reflex to ER, PR, HER2 by IHC; reflex to HER2/CEP17 FISH if 2+ by IHC; reflex to HERmark[®] if FISH equivocal (FISH ratio 1.8 - 2.2 or HER2 gene copy 4.0 - 6.0)⁺

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⁺
 480277 ER/PR (Estrogen Receptor/Progesterone Receptor) by IHC
 481051 MIB Ki-67 by IHC
 481044 p53 Tumor Suppressor Gene# by IHC
 511280 Tamoxifen P450 2D6 Genotype@ by PCR
 XL3 Flow Cytometry*[@]
 480952 PIK3CA Oncogene Mutation Detection#
 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⁺

- 483289 HER2 by IHC, reflex to HER2/CEP17 FISH if 2+ by IHC
 483248 HER2/CEP17 FISH
 482012 HERmark[®] Breast Cancer Assay
 483410 HER2/CEP17 FISH, reflex to HERmark[®] if FISH equivocal (FISH ratio 1.8 - 2.2 or HER2 gene copy 4.0 - 6.0)

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 08/03/2017 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	88361
p53 Tumor Suppressor Gene by IHC	88360#
Tamoxifen P450 2D6 Genotype by PCR	81226@
HER2 by IHC	88360
HER2/CEP17 by FISH	88377
Flow Cytometry Breast or Lymph Node	88184@, 88185x18@, 88189@
PIK3CA Oncogene Mutation Detection	81404#, 88381
Prosigna® Breast Cancer Prognostic Gene Signature Assay	0008M@, 88381

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

- † Wolff AC, Hammond ME, Hicks DG, et al. Recommendations for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer: American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Update. *J Clin Oncol*. 2013 Nov 1; 31(31): 3997-4013
- ★ 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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