

# Flow Cytometry Requisition



VERIPATH LABORATORIES

ACCOUNT INFORMATION	
Client Name/Account Number:	
Client Address:	
City/State/Zip:	
Client Phone:	Client FAX:

2110 Research Row, Suite 221  
 Dallas, Texas 75235  
 PHONE: 214-645-7057  
 Toll Free: 877-887-8136  
 FAX: 214-645-7035  
 CLIA #45D-0659587, CAP #2723201

www.veripathlabs.com

## REQUIRED ORDER INFORMATION

BILL TO:	
<input type="checkbox"/> Facility / Client	<input type="checkbox"/> Patient / 3rd party – Billing information must be provided
Patient Name: (Last, First, Middle)	
Mother's Name: (if infant)	
Date of Birth:	Sex: Patient ID / MR#:
Hospital Inpatient Y / N	Collection Date: Collection Time: AM PM
Ordering Physician:	NPI:
Phone:	Pager: FAX:
Clinical Indication for Tests Ordered:	

## PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s)	
Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side.	
<input type="checkbox"/> Signed ABN included	
ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.	
Insured/Responsible Party Name: (if different from patient-Last, First, Middle)	Date of Birth:
Patient's relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Responsible Party Address: (street, city, State, zip)
Sex:	Phone:
Employer's Name:	Employer's Phone:
Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	
Policy #:	Group #:
<input type="checkbox"/> Medicare <input type="checkbox"/> HMO <input type="checkbox"/> Other <input type="checkbox"/> Medicaid <input type="checkbox"/> PPO	Member ID#:
Referral Authorization/Precertification #:	
Name:	Date/Time:

## SPECIMEN INFORMATION

<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Body Fluid (source): _____
<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> HPC-A(PBSC) #: _____
<input type="checkbox"/> CSF	<input type="checkbox"/> Biopsy (source): _____
<input type="checkbox"/> Umbilical cord	<input type="checkbox"/> Tissue (source): _____
	<input type="checkbox"/> FNA (source): _____
	<input type="checkbox"/> Other: _____

**NOTE:** Submit one specimen per container CLEARLY LABELED.  
 Submit smear and CBC copy when requesting analysis of marrow or blood.

## CLINICAL INFORMATION

Primary Physician: (if different from above)		
Phone:	Pager:	FAX:

## FOR IMMUNOPHENOTYPING CASES ONLY

<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Mediastinal Mass	<input type="checkbox"/> Splenomegaly
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## FOR ALL CASES

Current Therapy	Current Infection
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> HIV
<input type="checkbox"/> Growth Factor	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Immunotherapy: _____	
<input type="checkbox"/> Other: _____	

## TEST REQUESTED

### IMMUNOPHENOTYPING:

<input type="checkbox"/> IP Panel [F/IP PANEL]
<input type="checkbox"/> Leukemia/Lymphoma Immunophenotyping
<input type="checkbox"/> PNH panel (Paroxysmal Nocturnal Hemoglobinuria)
<input type="checkbox"/> ALPS (Autoimmune Lymphoproliferative Syndrome)
<input type="checkbox"/> Process and hold sample for Immunophenotypic analysis (call next day with instructions)
<input type="checkbox"/> Other Markers: _____

### IMMUNODEFICIENCY WORKUP:

Must Provide:	
WBC count _____ 10 <sup>3</sup> /μL	Lymphs _____ %
	Atypical Lymphs _____ %
<input type="checkbox"/> T & B Cell subset quantification, including NK's (CD3, CD4, CD8, CD19, CD16+56) [F/LYMSUB]	
<input type="checkbox"/> CD4 quantification (HIV monitoring) [F/CD4PANEL]	
<input type="checkbox"/> CD3 quantification (Transplant monitoring) [F/CD3TRANS]	
<input type="checkbox"/> T-Cell subset quantification (CD3, CD4, CD8) [F/TCELLSUB]	
<input type="checkbox"/> Extended Lymph Subset Panel [F/EXTLYSUB]	
<input type="checkbox"/> B-Cell Total Count (CD19) [F/B TOTAL]	
<input type="checkbox"/> B & NK Cell Subset Panel (CD19 & CD16+56) [F/B SUBSET]	
<input type="checkbox"/> NK Cell Total Count (CD16+56) [F/NK CELL]	

VERIPATH USE ONLY	Transport Container:	Total # of specimens: _____	Transport Conditions:	Destination:	Initials:
	<input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Purple <input type="checkbox"/> Syringe <input type="checkbox"/> Conical <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Cup		<input type="checkbox"/> Frozen <input type="checkbox"/> Slushy	<input type="checkbox"/> Aston <input type="checkbox"/> Coag <input type="checkbox"/> Cytogen	
	<input type="checkbox"/> Trans Tube <input type="checkbox"/> Block <input type="checkbox"/> Slides <input type="checkbox"/> Formalin <input type="checkbox"/> Other: _____		<input type="checkbox"/> Refrig <input type="checkbox"/> Room Temp	<input type="checkbox"/> Flow <input type="checkbox"/> Hist <input type="checkbox"/> Mol Dx <input type="checkbox"/> OncoDx	

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) \_\_\_\_\_ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**(G) OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**(H) Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

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