

Cancer Cytogenetics Requisition

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



VERIPATH LABORATORIES

www.veripathlabs.com

REQUIRED ORDER INFORMATION

BILL TO: Facility / Client
 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:

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side. 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: Self Spouse Dependent 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 #:
 Medicare HMO Other Medicaid PPO
 Member ID#:
 Referral Authorization/Precertification #:
 Name: Date/Time:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

Blood (Submit only if marrow is unobtainable) [C/CYTOCANC]
 Bone marrow __ aspirate __ biopsy [C/CYTOCANC]
 Tumor: site/type _____ [C/CYTOCANC]
 Other: _____ [C/CYTOCANC]

Initial Diagnosis? No Yes
 S/P transplant? No Yes - Donor Sex M / F

DIAGNOSTIC INFORMATION

DIAGNOSIS Confirmed Suspected

Hematologic disorders: <input type="checkbox"/> ALL <input type="checkbox"/> Lymphoma* <input type="checkbox"/> AML, FAB type _____ <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> CLL <input type="checkbox"/> Myeloproliferative disorder* <input type="checkbox"/> CML <input type="checkbox"/> Myelodysplastic disorder* <input type="checkbox"/> Cytopenia* <input type="checkbox"/> Other: _____	Tumors: <input type="checkbox"/> Ewing sarcoma/PNET <input type="checkbox"/> Germ cell tumor <input type="checkbox"/> Rhabdomyosarcoma <input type="checkbox"/> Hepatoblastoma <input type="checkbox"/> Synovial sarcoma <input type="checkbox"/> Lymphoma* <input type="checkbox"/> Wilms tumor <input type="checkbox"/> Neuroblastoma <input type="checkbox"/> Other: _____
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*Specify Type/Additional History: _____

TEST REQUESTED

Check one Chromosomal Analysis Chromosomal Analysis with FISH (Specify FISH below) FISH only (Specify below)

FISH TESTS: <input type="checkbox"/> BCR/ABL: t(9;22) [CML/ALL/AML] <input type="checkbox"/> ETO/AML1: t(8;21) [AML] <input type="checkbox"/> CFBF: inv(16): [AML] <input type="checkbox"/> PML/RARA: t(15;17) [AML] <input type="checkbox"/> deleted 5: [MDS] <input type="checkbox"/> deleted 7: [MDS] <input type="checkbox"/> TEL/AML1: t(12;21) [ALL]	<input type="checkbox"/> MYC/IGH: t(8;14) [ALL] <input type="checkbox"/> BCL1/IGH: t(11;14) [mantle cell lymphoma] <input type="checkbox"/> API2/MALT1: t(11;18) [marginal zone lymphoma] <input type="checkbox"/> IGH/BCL2: t(14;18) [follicular lymphoma] <input type="checkbox"/> MLL: 11q23 <input type="checkbox"/> RB1: 13q14 <input type="checkbox"/> P53: 17p13.1 <input type="checkbox"/> CHIC2: deleted 4q [hypereosinophilic syndrome]	Solid Tumors <input type="checkbox"/> EWSR1: [Ewing sarcoma] <input type="checkbox"/> NMYC: [neuroblastoma] <input type="checkbox"/> FKHR: 13q14 [alveolar rhabdomyosarcoma] <input type="checkbox"/> SYT: 18q11.2 [synovial sarcoma] <input type="checkbox"/> FUS: 16p11.2 [myxoid sarcoma]
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Transplant (opposite sex donor)
 X/Y sex chromosomes

FISH PANELS: CLL Panel Multiple Myeloma Panel MDS Panel
 Other FISH (please call lab): _____

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.