

Phone: 844-405-9655

Email: labsupport@interpace.com

Fax: 888-674-6894

interpace.com

**① Patient Information**

Please print or adhere patient label. Must include two (2) unique identifiers.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN/MRN: \_\_\_\_\_ Gender:  M  F

**③ Billing Information**

**Procedure Location:**

- Outpatient  Non-Hospital Affiliated Setting  
 Private Practice  Inpatient/Discharge Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

ICD CODE: \_\_\_\_\_

*Codes for your consideration (please do not circle, see reverse side for more information):*  
**E04.2** Nontoxic, multinodular goiter thyroid gland    **E04.1** Nontoxic, single thyroid nodule  
**D44.0** Neoplasm of uncertain behavior of thyroid gland    **D34.0** Benign neoplasm of thyroid

The diagnosis code(s) provided should always be based upon what can be supported within the patient's medical records. Testing cannot be done unless ICD code(s) are included.

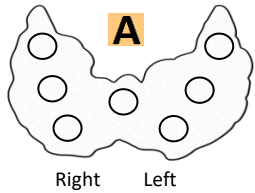
**④ Specimen & Diagnosis Information**

Please indicate type and number submitted

**Submitted Specimen(s):** For multiple nodules, indicate the locations on the diagram and correlate with labels attached below.

**Specimen A**

- 1 Collection Buffer Vial      \_\_\_\_ # Alcohol-Fixed Slides  
 1 Vial CytoLyt® Solution      \_\_\_\_ # Air-Dried Slides

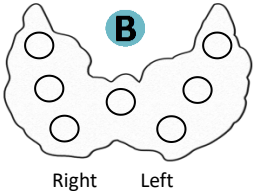


Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**A** \_\_\_\_\_  
Size: \_\_\_\_\_

**Specimen B**

- 1 Collect Buffer Vial      \_\_\_\_ # Alcohol-Fixed Slides  
 1 Vial CytoLyt® Solution      \_\_\_\_ # Air-Dried Slides



Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**B** \_\_\_\_\_  
Size: \_\_\_\_\_

**Ultrasound Characteristics (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>A</b> <input type="checkbox"/> Peripheral Vascularity | <input type="checkbox"/> <b>A</b> <input type="checkbox"/> Rim Calcifications |
| <input type="checkbox"/> <input type="checkbox"/> Intranodular Vascularity        | <input type="checkbox"/> <input type="checkbox"/> Macrocalcifications         |
| <input type="checkbox"/> <input type="checkbox"/> Avascular                       | <input type="checkbox"/> <input type="checkbox"/> Microcalcifications         |
| <input type="checkbox"/> <input type="checkbox"/> Hyperechoic                     | <input type="checkbox"/> <input type="checkbox"/> Isoechoic                   |
| <input type="checkbox"/> <input type="checkbox"/> Hypoechoic                      |   |

Clinical History/Comments: \_\_\_\_\_

**② Physician Information**

**Submitting Physician**

Account #:  
Office/Hospital:  
Address:  
Phone:  
Fax:  
Office Contact:  
Email:

Institution NPI:  
Physician NPI:

**Referring/Treating Physician**

Account #:  
Office/Hospital:  
Address:  
Phone:  
Fax:  
Office Contact:  
Email:  
Contact Preference:  
 No Contact  CC Test results

Institution NPI:  
Physician NPI:

**⑤ Method of Payment Information**

**A COPY OF THE PATIENT'S BILLING AND DEMOGRAPHICS INFORMATION IS REQUIRED FOR TESTING. FAILURE TO SUPPLY THIS INFORMATION WILL DELAY RESULTS.**

- Medicare  Medicaid  Private Insurance  Ordering Institution  Self Pay

Interpace Diagnostics will bill directly for insured patients, wherever permitted by government regulations, payer billing policies, or contractual arrangements. If patient or insurance information is not completed or attached, your facility will be billed.

**⑥ Test Menu and Authorization**

Molecular reflex occurs when cytopathology results are Bethesda Category III, IV, or V.

- Cytology + Reflex to ThyGeNEXT® w/ Reflex to ThyraMIR®**  
ThyGeNEXT w/ Reflex to ThyraMIR better discriminates benign from malignant nodules and provides risk assessment. TERT and BRAF V600E and other mutations (BRAF-like mutations) that are highly predictive of malignancy are included in ThyGeNEXT. Also other mutations less predictive of thyroid cancer (RAS-like mutations) are also included in ThyGeNEXT. If mutations in ThyGeNEXT are negative or not fully predictive of malignancy, ThyraMIR testing will be performed in reflex.

- Cytology + Reflex to ThyGeNEXT only  
 ThyGeNEXT w/ Reflex to ThyraMIR  
 ThyGeNEXT only

I hereby certify that the request for the above test for which reimbursement from Medicare or third-party payors will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also authorize providing this patient's test results to the patient's third-party payor. I certify that the treating physician has ordered the above test.

**MD/DO Signature:** \_\_\_\_\_

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

Order Date: \_\_\_\_\_

<p>Specimen <b>A</b></p> <p>Patient Name: DOB:</p> <p>Specimen <b>B</b></p> <p>Patient Name: DOB:</p>	<p>Specimen <b>A</b></p> <p>Patient Name: DOB:</p> <p>Specimen <b>B</b></p> <p>Patient Name: DOB:</p>	<p>Specimen <b>A</b></p> <p>Patient Name: DOB:</p> <p>Specimen <b>B</b></p> <p>Patient Name: DOB:</p>	<p>Specimen <b>A</b></p> <p>Patient Name: DOB:</p> <p>Specimen <b>B</b></p> <p>Patient Name: DOB:</p>
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