

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 2 unique identifiers.

Last Name	First Name
Date of Birth (mm/dd/yy)	SSN/MRN
Biological Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

## 3. Billing Information

### Procedure Location

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

ICD Code(s)

**Codes for your consideration** (please do not circle, see reverse side for more information)

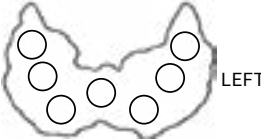
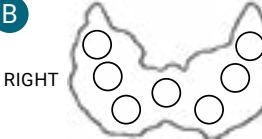
**E04.2** Nontoxic, multinodular goiter thyroid gland  
**E04.1** Nontoxic, single thyroid nodule  
**D44.0** Neoplasm of uncertain behavior of thyroid gland  
**D34** Benign neoplasm of thyroid

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.

For multiple nodules, indicate the locations on the diagram and correlate with labels attached below.

A	B
	
<input type="checkbox"/> 1 Collection Buffer Vial <input type="checkbox"/> 1 Vial CytoLyt <sup>®</sup> Solution ____ # Alcohol-Fixed Slides ____ # Air-Dried Slides	<input type="checkbox"/> 1 Collection Buffer Vial <input type="checkbox"/> 1 Vial CytoLyt <sup>®</sup> Solution ____ # Alcohol-Fixed Slides ____ # Air-Dried Slides
Collection Date _____	Collection Date _____
Location _____	Location _____
Size _____	Size _____

Clinical History/Comments

Please attach a copy of the Ultrasound Report

## 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 ☐ Self Pay ☐ Ordering Institution

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.

## 2. Physician Information

Submitting Physician	Referring/Treating Physician
Account #:	Account #:
Office/Hospital:	Office/Hospital:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Office Contact:	Office Contact:
Email:	Email:
Institution NPI:	Contact Preference: <input type="checkbox"/> No Contact <input type="checkbox"/> CC Test Results
Physician NPI:	Institution NPI:
	Physician NPI:

## 6. Test Menu and Authorization

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

- ☐ Cytology + Reflex to ThyGeNEXT<sup>®</sup> w/Reflex to ThyraMIRv2<sup>®</sup>  
☐ ThyGeNEXT<sup>®</sup> w/Reflex to ThyraMIRv2<sup>®</sup>

ThyGeNEXT w/Reflex to ThyraMIRv2 better discriminates benign from malignant nodules providing further risk assessment. *BRAF* V600E-like mutations that are highly predictive of malignancy are included in ThyGeNEXT. *RAS*-like mutations, which are less predictive of malignancy, are also included in ThyGeNEXT. If ThyGeNEXT is negative for mutations or not fully predictive of malignancy, ThyraMIRv2 testing will be performed in reflex.

- ☐ Cytology + Reflex to ThyGeNEXT<sup>®</sup> only  
☐ ThyGeNEXT<sup>®</sup> only

ThyGeNEXT includes the most common mutations associated with all types of thyroid cancer. When identified, these *BRAF* V600E-like mutations are highly predictive of malignancy. This selection does not provide the benefit of ThyraMIRv2 for further risk stratification when no mutation or a *RAS*-like mutation is identified.

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	Order Date
Print Name	

## Requisition Instructions

Incomplete or incorrect information will lead to testing delays.

### Section 1. Patient Information

All fields are required. Include patient first and last name, date of birth, SSN/MRN code, and biological sex. A complete patient label can be adhered in this field as long as patient information is complete and includes 2 unique identifiers. **Incomplete information will result in testing delays.**

### Section 2. Physician Information

This section may be pre-filled if an account has been set up with Interpace Diagnostics. If blank, complete each field. Account Number should match your Interpace Diagnostics account number (leave blank if unknown). Complete physician institution contact information. Please avoid Office/Hospital acronyms or abbreviations and spell out the institution name. **Referring/Treating Physician:** Please provide full name and phone/fax number for referring/treating physician, if applicable. Check the box to indicate if you would like the referring/treating physician to receive a copy of the results. **Leaving contact information incomplete will result in processing delays.**

### Section 3. Billing Information

Check the box to indicate where procedure was performed (Nonhospital affiliated setting, Private Practice, Outpatient, or Inpatient with discharge date).

**Testing cannot be performed unless ICD-10 code(s) are included.** Write in the appropriate ICD-10 code based on the patient's medical records. The ICD diagnosis code must be defined by the most detailed level of specificity available. If a diagnosis code cannot be supported by the patient's medical record, then the code should not be used for ordering laboratory services. The list of common ICD diagnosis codes for the characterization of thyroid nodules shown below is not complete. Please refer to the ICD manual for a complete listing.

#### Common ICD-10 Diagnosis Codes:

D34 - Benign neoplasm of thyroid gland  
D44.0 - Neoplasm of uncertain behavior of thyroid gland  
D44.9 - Neoplasm of uncertain behavior of unspecified endocrine gland  
E01.0 - Iodine-deficiency related diffuse (endemic) goiter  
E01.1 - Iodine-deficiency related multinodular (endemic) goiter  
E01.2 - Iodine-deficiency related (endemic) goiter, unspecified  
E04.0 - Nontoxic diffuse goiter  
E04.1 - Nontoxic single thyroid nodule  
E04.2 - Nontoxic multinodular goiter  
E04.8 - Other, specified nontoxic goiter  
E04.9 - Nontoxic goiter, unspecified

### Section 4. Specimen & Diagnosis Information

**Submitted Specimen(s):** Check the box to indicate the type of specimen being sent for testing OR indicate the number of slides being sent (REQUIRED). If submitting multiple nodules, indicate type and quantity separately.

**Specimen Collection Date:** Enter the date of the procedure when the specimen was collected. Mark the circle on the thyroid diagram to indicate location of the nodule. The requisition can be used to submit specimens for up to 2 locations. Use letter A for the first specimen and letter B for the second specimen. Provide a descriptive name for each location on the line provided, along with the size of each nodule.

**Ultrasound Report:** Please provide a copy of the patient's ultrasound report and/or relevant supporting documentation.

Please refer to the Directory of Services for full information on accepted specimens types and submission requirements. Visit [www.thygenext-thyramir.com/dos](http://www.thygenext-thyramir.com/dos).

### Section 5. Method of Payment Information

Check the box indicating how the testing should be billed. Interpace Diagnostics will submit claims to all private insurance, Medicare, and other government plans for insured patients.

**Patient Contact Information:** Please provide a copy of the patient's face sheet or demographics page to include the patient's full name, biological sex, date of birth, address, and phone number.

**A copy of the patient's billing information MUST be submitted with specimen.**

**Medicare/Medicaid/Private Insurance:** Provide a clear copy of the front and back of the patient's primary insurance/Medicaid/other payer card. If the patient has a secondary insurance please provide a clear copy of the front and back of the secondary insurance card.

**Ordering Institution:** Check this box if Interpace Diagnostics is to bill the ordering institution for the ordered testing.

**Patient Self-Pay (no insurance):** Check this box if the patient has no insurance.

### Section 6. Test Menu and Authorization

Specimen processing cannot begin until there is a clear indication of the type of testing to be performed (check box). Please indicate tests requested for patient specimen. Details of each test can be found on our website and in test details from our Directory of Laboratory Services. Only 1 test should be selected (duplicate test selections within a Test Requisition Form cannot be processed and can delay testing).

**The ordering physician is required to sign and date the requisition as authorization for Interpace Diagnostics to perform testing.** Stamped signatures or physician initials cannot be accepted. An incomplete signature will result in testing delays. Order date cannot precede Collection Date of the specimen. **Post-dated requisitions are not accepted.**

### Questions?

**Contact Interpace Diagnostics Customer Service at:**

**Phone:** 844-405-9655 or 412-224-6900

**Fax:** 1-888-674-6894 or 412-224-6425

**Email:** [clientservices@interpace.com](mailto:clientservices@interpace.com)

**Website:** [www.interpace.com](http://www.interpace.com)