

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):**

\_\_\_\_\_ # FNA in Collection Buffer Vial(s)

\_\_\_\_\_ # Cytology Slide(s)

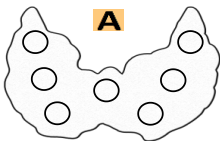
**Submitted Collection Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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

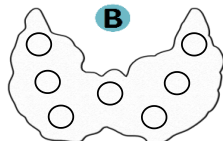
**A** \_\_\_\_\_ **B** \_\_\_\_\_

Size: \_\_\_\_\_

Size: \_\_\_\_\_



Right Left



Right Left

**Cytology Diagnosis (Bethesda Category):**

- |   |  |
|---|--|
| <b>A</b> <input type="checkbox"/> Atypical/FLUS (III) | <b>A</b> <input type="checkbox"/> Nondiagnostic (I)* |
| <input type="checkbox"/> Suspicious for Neoplasm (IV) | <input type="checkbox"/> Benign (II)*                |
| <input type="checkbox"/> Suspicious for Cancer (V)    | <input type="checkbox"/> Malignant (VI)*             |
- \*Requires Letter of Medical Necessity (LOMN)

**PLEASE ATTACH A COPY OF THE CYTOLOGY REPORT**

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

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

**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.

**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: \_\_\_\_\_

Specimen **A**

Patient Name:  
DOB:

Specimen **A**

Patient Name:  
DOB:

Specimen **B**

Patient Name:  
DOB:

Specimen **B**

Patient Name:  
DOB:

**\*\*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 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 acronym or abbreviations & 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 indicating how the testing should be billed. Interpace Diagnostics will submit claims to all private insurance, Medicare and other government plan for insured patients.

**Private Insurance/Medicare/Medicaid:** 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.

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

**Submitting Diagnosis:** Write in appropriate ICD-10 code based on the patient's medical records. The diagnosis code(s) provided should always be supported by documentation within the patient's medical records. Testing cannot be performed unless ICD-10 code(s) are included. The ICD diagnosis code must be defined by the most detailed level of specificity available and should always be based on what has been documented in the patient's medical record. 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:**

- D34.0- 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**

**Specimen & Diagnosis:** Check the box to indicate where procedure was performed (Non-hospital affiliated setting, Private Practice, Outpatient, or Inpatient with discharge date).

**Submitted Specimen(s):** Check the box to indicate type of specimen being sent in for testing OR indicate 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 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 the 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.

**Cytology Diagnosis (Bethesda Category):** Check the box that corresponds with the patients' medical records to indicate the cytology diagnosis. A copy of the corresponding cytology report is requested to be sent with this specimen, as available. If these reports are not available at time of specimen submission, please forward to Client Services (fax: 1-888-674-6894 or 412-224-6425) when received. Please note that for Bethesda I, II, and VI categories a Letter of Medical Necessity is required to start testing.

**Ultrasound Characteristics:** Indicate key characteristics identified from patient's medical records & ultrasound report. Provide relevant clinical history for the patient. Please provide relevant medical records at no cost when requested by the patient's insurance carrier for reimbursement.

**Section 5. Test Menu**

Specimen processing cannot begin until there is a clear indication of 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.

**Section 6. Authorization**

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)



**Interpace Diagnostics**<sup>®</sup>  
Resolving Diagnostic Uncertainty