INTERPACE DIAGNOSTICS
GUIDING TREATMENT. DELIVERING INNOVATION.

REQUISITION FOR FIRST-LINE TESTING or STORAGE

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Include completed requisition with sample | **Client Services: 800-495-9885 | labsupport@interpacediagnostics.com**

PancraGen™ Integrated molecular testing is also available. Please contact Client Services for additional information or questions.

1. PROCEDURE DETAILS

COLLECTION DATE _____ (MM/DD/YYYY) TIME _____ (HH:MM) ☐ AM ☐ PM

SPECIMEN COLLECTION SETTING

☐ HOSPITAL (INPATIENT): Date of Discharge _____ (MM/DD/YYYY)

☐ HOSPITAL (OUTPATIENT) ☐ NON-HOSPITAL AFFILIATED SETTING

☐ **EUS REPORT attached**

2. SPECIMEN QUANTITIES

EACH VIAL MUST BE LABELED WITH SPECIMEN ID & TWO PATIENT IDENTIFIERS

☐ PANCREATIC CYST FLUID ☐ PANCREATIC DUCT FLUID

☐ PANCREATIC MASS ☐ SUPERNATANT PANCREAS

☐ SUPERNATANT BILIARY ☐ ERCP BILIARY

☐ ERCP PANCREAS ☐ OTHER _____

1. SPECIMEN ID _____
   Number of tubes submitted: ☐1 ☐2 ☐3 ☐ _____
2. SPECIMEN ID _____
   Number of tubes submitted: ☐1 ☐2 ☐3 ☐ _____
3. SPECIMEN ID _____
   Number of tubes submitted: ☐1 ☐2 ☐3 ☐ _____

SUPERNATANT MEDIA:

☐ CYTOLYT ☐ PRESERVCYT ☐ RPMI ☐ OTHER_____

SUBMITTED CONTROL REQUIRED:

☐ BUCCAL BRUSH or ☐ BLOOD (EDTA, ACD-A, or ACD-B tube)

3. TESTS REQUESTED or STORAGE

TESTS REQUESTED: 1 mL

☐ ACCUCEA™ CPT 82378

☐ AMYLASE CPT 82150

☐ STORAGE ONLY

WHEN FLUID TESTING IS ORDERED, INTERPACE DIAGNOSTICS WILL STORE ANY EXCESS FLUID FOR POSSIBLE FUTURE MOLECULAR TESTING UP TO 25 DAYS AFTER THE COLLECTION DATE.

4. SIGNATURE

☐ I hereby authorize review of this patient's results by an Interpace Diagnostics representative for potential discussion with me, the ordering physician.

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 patient or referring physician has given consent to the test I have ordered.

SIGNATURE _____

ORDER DATE _____ (MM/DD/YYYY) PRINT NAME _____

5. PATIENT INFORMATION (may adhere patient label)

PATIENT NAME _____ (Last Name, First, MI)

DATE OF BIRTH _____ (MM/DD/YYYY) SEX: ☐ FEMALE ☐ MALE

SSN or MRN _____

6. BILLING INFORMATION

☐ PATIENT BILLING INFORMATION ATTACHED (Face Sheet, Photocopies of Cards, etc)

BILL TO:

☐ MEDICARE ☐ PRIVATE INSURANCE ☐ ORDERING INSTITUTION

☐ MEDICAID ☐ PATIENT PRE-PAY (US check, cert. funds, etc.)

INTERPACE DIAGNOSTICS WILL BILL DIRECTLY FOR COVERED PATIENTS, WHEREVER PERMITTED BY GOVERNMENT REGULATIONS, PAYER BILLING POLICIES, OR CONTRACTUAL ARRANGEMENTS. IF PATIENT OR INSURANCE INFORMATION IS NOT COMPLETED OR ATTCHED, YOUR FACILITY WILL BE BILLED.

7. SUBMITTING DIAGNOSIS

ICD CODES (REQUIRED):

PLEASE PROVIDE ALL APPLICABLE DIAGNOSIS CODES:

_____ _____ _____

THE DIAGNOSIS CODE(S) PROVIDED SHOULD ALWAYS BE BASED UPON WHAT CAN BE SUPPORTED WITHIN THE PATIENT'S MEDICAL RECORD. TESTING CANNOT BE DONE UNLESS ICD CODE(S) ARE INCLUDED.

8. PROVIDER INFORMATION

ORDERING INSTITUTION: _____

COLLECTING INSTITUTION: _____

ORDERING PHYSICIAN(S): NPI TEL FAX

FAX ADD'L REPORTS TO: _____

9. STAFF CONTACT

STAFF CONTACT _____

PHONE _____ FAX _____

INTERPACE USE ONLY: Rec'd by: _____ Date/Time Rec'd: _____