

Phone: 844-405-9655 Email: LabSupport@interpacedx.com Fax: 888-674-6894 InterpaceDiagnostics.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: _____ Sex: M F

② Physician Information

Submitting Physician

Account #: _____

Office/Hospital: _____

Address: _____

Phone: _____

Fax: _____

Email: _____ Office Contact: _____

NPI #: _____

Results Delivery: Fax Mail

Referring/Treating Physician

Office/Hospital: _____

Physician Name: _____

Phone: _____ Fax: _____

③ Billing Information

A COPY OF THE PATIENT'S BILLING INFORMATION MUST BE SUBMITTED.

- 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.

④ Specimen & Diagnosis Information

Procedure Location:

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

Submitted Specimen(s):

Specimen A

1 RNARetain® Vial* _____ # Alcohol-Fixed Slides

1 Vial CytoLyt® Solution _____ # Air-Dried Slides

Specimen Collection Date: ____/____/____

Specimen B

1 RNARetain® Vial* _____ # Alcohol-Fixed Slides

1 Vial CytoLyt® Solution _____ # Air-Dried Slides

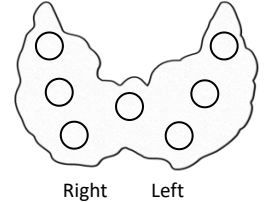
Ultrasound Characteristics (check all that apply)

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

Indicate the location of the nodule on the diagram.

Nodule Size **A**: _____

Nodule Size **B**: _____



Submitting Diagnosis:

ICD 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.

Codes for your consideration (please do not circle):

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

⑤ Test Menu

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 mutations are included in ThyGeNEXT®. If mutations in ThyGeNEXT® are negative or not fully indicative of malignancy, ThyraMIR® testing will be performed in reflex.
- Cytology + Reflex to ThyGeNEXT® only
- ThyGeNEXT® w/ Reflex to ThyraMIR®
- ThyGeNEXT® only

⑥ Authorization

MD/DO Signature _____

Print Name: _____

Order Date: _____

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.

Specimen A Patient Name: DOB:	Specimen A Patient Name: DOB:	Specimen A Patient Name: DOB:	Specimen A Patient Name: DOB:	Specimen A Patient Name: DOB:
Specimen B Patient Name: DOB:	Specimen B Patient Name: DOB:	Specimen B Patient Name: DOB:	Specimen B Patient Name: DOB:	Specimen B Patient Name: DOB: