INTERPACE™ DIAGNOSTICS
GUIDING TREATMENT. DELIVERING INNOVATION.

REQUISITION FOR MOLECULAR ANALYSIS (HISTOLOGY/CYTOLOGY SPECIMENS)

H

Include completed requisition with sample | **Client Services: 844-227-7621 | labsupport@interpacediagnostics.com**

CLINICAL REPORTS

TEST REPORTS SUBMITTED FOR THIS CASE:

☐ PATHOLOGY REPORT ☐ OTHER: ____________________ ____________________

☐ ENDOSCOPY REPORT

SUBMITTING DIAGNOSIS

ICD CODES (REQUIRED):

________________ ________________ ________________

________________ ________________ ________________

Please indicate ALL applicable diagnosis codes above.

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.

SPECIMEN INFORMATION

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

DATE PULLED FROM STORAGE ________________________________

SPECIMEN DESCRIPTION ________________________________

____

PATHOLOGY Nos. ____________________ ____________________

☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)

#_____STAINED #_____UNSTAINED

☐ CYTOLOGY SLIDES (PAPNICOLAOU STAINED)

#______SLIDES FROM: (check box below)

☐ CYTOSPIN ☐ SMEAR ☐ CELL BLOCK

REQUIRED FOR MEDICARE PATIENTS

If this test is ordered more than 14 days after discharge, you must identify factors that affected the time of ordering the test.

REASON CODES

☐ 1. COMPLEX CASE required extensive review and deliberation

☐ 2. INCONCLUSIVE DIAGNOSIS after initial workup; molecular studies ordered for additional data

☐ 3. REVIEW OF INITIAL TEST RESULTS WITH PATIENT required prior to ordering additional studies

☐ 4. CONSULTATION WITH OTHER PHYSICIAN(S) required time to schedule and obtain their input

☐ 5: OTHER: ____

PATIENT INFORMATION (may adhere patient label)

PATIENT NAME ____ (Last Name, First, MI)

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

STREET ADDRESS ____

CITY __________________________ STATE _____ ZIP __________

PHONE # ____________________ SSN or MRN ____________________

☐ PATIENT'S DEMOGRAPHIC INFORMATION ATTACHED (FACE SHEET)

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.)

INSURANCE NAME ____

POLICY # ____________________ GROUP # ____________________

POLICY HOLDER NAME ____

DATE OF BIRTH ____ (MM/DD/YYYY)

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.

PROVIDER INFORMATION

ORDERING INSTITUTION:____

____

____

COLLECTING INSTITUTION:____

____

ORDERING PHYSICIAN(S): NPI TEL FAX

FAX ADD'L REPORTS TO: ____

SIGNATURE

Order PathFinderTG by signing and dating this section.

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.

PHYSICIAN SIGNATURE ____

PRINT NAME ________________________ DATE SIGNED ____________ (MM/DD/YYYY)

STAFF CONTACT ____

PHONE ____________________________ FAX ____________________

INTERPACE DIAGNOSTICS GUIDING TREATMENT. DELIVERING INNOVATION. INTERPACE USE ONLY: Rec'd by: ____________________ Date/Time Rec'd: ________________