

Phone: 800-495-9885

Email: LabSupport@interpacedx.com

Fax: 888-674-6894

InterpaceDiagnostics.com

① Patient Information		② Physician Information	
Please print or adhere patient label. Must include two (2) unique identifiers.		Submitting Physician	
Last Name: _____ First Name: _____ Date of Birth (mm/dd/yy): ____/____/____ SSN/MRN: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Account #: _____ Office/Hospital: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Office Contact: _____ NPI: _____	
③ Billing Information		Referring/Treating Physician	
A copy of the patient's billing information must be submitted.		Office/Hospital: _____ Physician Name: _____ Phone: _____ Fax: _____	
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Ordering Institution <input type="checkbox"/> 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.			
Procedure Location: <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Affiliated <input type="checkbox"/> Inpatient / Discharge Date: ____/____/____ <input type="checkbox"/> Private Practice			
Submitting Diagnosis: ICD-10 Codes: _____ <i>The diagnosis code(s) provided should always be supported by the documentation within the patient's medical record. Testing cannot be done unless ICD code(s) are included.</i>			
④ Specimen Information			
Use additional requisitions for additional specimens.			
Specimen 1		Specimen 2	
Collection Date (mm/dd/yy): ____/____/____		Collection Date (mm/dd/yy): ____/____/____	
Organ / Tissue: _____		Organ / Tissue: _____	
Pathology NO: _____		Pathology NO: _____	
<input type="checkbox"/> Histology Slides (H&E + 8 Unstained): # Stained ____ # Unstained ____		<input type="checkbox"/> Histology Slides (H&E + 8 Unstained): # Stained ____ # Unstained ____	
<input type="checkbox"/> Cytology Slides (Papanicolaou Stained): # Slides ____ <input type="checkbox"/> CytoSpin <input type="checkbox"/> Smear <input type="checkbox"/> Cell Block		<input type="checkbox"/> Cytology Slides (Papanicolaou Stained): # Slides ____ <input type="checkbox"/> CytoSpin <input type="checkbox"/> Smear <input type="checkbox"/> Cell Block	
<input type="checkbox"/> Paraffin Embedded Tissue Block		<input type="checkbox"/> Paraffin Embedded Tissue Block	
⑤ Reasons for Ordering (Required for Medicare)		⑥ Clinical Reports	
For inpatient procedures, if this test is ordered 14 or more days after the patient's discharge date, you must identify factors that affected the time of ordering Metastasis vs. Primary Tumor (e.g. RespriDx) testing. Reason Codes: <input type="checkbox"/> 1. COMPLEX CASE required extensive review and deliberation <input type="checkbox"/> 2. INCONCLUSIVE DIAGNOSIS after initial workup; molecular studies ordered for additional data <input type="checkbox"/> 3. REVIEW OF INITIAL TEST RESULTS WITH PATIENT required prior to ordering additional studies <input type="checkbox"/> 4. CONSULTATION WITH OTHER PHYSICIAN(S) required time to schedule and obtain their input <input type="checkbox"/> 5. OTHER _____		For each specimen submitted please attach the following: <input type="checkbox"/> Pathology (Required) <input type="checkbox"/> Cytology <input type="checkbox"/> Other _____	
⑦ Authorization			
Order Metastasis vs. Primary Tumor testing by completing, signing and dating this requisition.			
MD/DO Signature: _____ Print Name: _____ Order Date: ____/____/____			
<i>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.</i>			