METASTASIS VS PRIMARY TUMOR REQUISITION

INTERPACE DIAGNOSTICS
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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: _____

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.

Procedure Location: ☐ Outpatient ☐ Non-Hospital Affiliated ☐ Inpatient / Discharge Date: ___/___/___ ☐ Private Practice

Submitting Diagnosis:

ICD-10 Codes: _____ _____ _____

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.

4 Specimen Information

Use additional requisitions for additional specimens.

Specimen 1

Collection Date (mm/dd/yy): ____/____/____

Organ / Tissue: _____

Pathology NO: _____

☐ Histology Slides (H&E + 8 Unstained):
Stained _____ # Unstained _____

☐ Cytology Slides (Papanicolaou Stained):
Slides _____ ☐ CytoSpin ☐ Smear ☐ Cell Block

☐ Paraffin Embedded Tissue Block

Specimen 2

Collection Date (mm/dd/yy): ____/____/____

Organ / Tissue: _____

Pathology NO: _____

☐ Histology Slides (H&E + 8 Unstained):
Stained _____ # Unstained _____

☐ Cytology Slides (Papanicolaou Stained):
Slides _____ ☐ CytoSpin ☐ Smear ☐ Cell Block

☐ Paraffin Embedded Tissue Block

5 Reasons for Ordering (Required for Medicare)

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:

☐ 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 _____

6 Clinical Reports

For each specimen submitted please attach the following:

☐ Pathology (Required)
☐ Cytology
☐ Other _____

7 Authorization

Order Metastasis vs. Primary Tumor testing by completing, signing and dating this requisition.

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.