

**PHYSICIAN INFORMATION**
**PATIENT INFORMATION**

Requesting Physician Signature _____ Referring Physician _____	Last Name _____ First Name _____ MI _____ Date of Birth _____ Street Address _____ City _____ State _____ Zip _____ Gender <input type="checkbox"/> F <input type="checkbox"/> M _____ ( ) - _____ Chart Number _____ Patient Telephone No. _____
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**BILLING INFORMATION REQUIRED (Attach copies of Insurance card: Primary and Secondary)**

If minor, Guardian Name \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_ Relation to Patient:  self  spouse  guardian

Insured's Name \_\_\_\_\_ Insured Employer \_\_\_\_\_

Bill Insurance    
  Uninsured    
  Indigent Patient    
  Bill Doctor    
  Medicare Waiver on Back(ABN)

**CLINICAL HISTORY REQUIRED**

Has UniPath performed testing on this patient?  Yes  No

Clinical History (May attach recent summary of patient history) \_\_\_\_\_

Diagnosis under consideration/Clinical question to be addressed: \_\_\_\_\_

**Indication for Flow Cytometry Testing:**

Enlarged Lymph Nodes: Location \_\_\_\_\_    
  Increased Lymphs on Cytology Report: Date \_\_\_\_\_    
  Abn. Histology Findings: Date \_\_\_\_\_  
 Leukemia/Lymphoma: Specify \_\_\_\_\_ Treatment \_\_\_\_\_    
  Carcinoma: Type \_\_\_\_\_  
 HIV and/or other Retro Virus \_\_\_\_\_    
  Auto Immune Disease: Type \_\_\_\_\_    
  Malignancy: Type \_\_\_\_\_  
 Transplanted Organ \_\_\_\_\_    
  Anemia-Aplastic or Other Type \_\_\_\_\_    
  Other \_\_\_\_\_

**SPECIMEN INFORMATION**

Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_ Specimen ID #(s): \_\_\_\_\_ **ICD-9 Code REQUIRED:** \_\_\_\_\_

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

<input type="checkbox"/> <b>Tissue</b> Site: _____ Transport Media: <input type="checkbox"/> RPMI <input type="checkbox"/> Other _____ (Req. RPMI) Number of TouchPrep Slides Sent: _____	<input type="checkbox"/> <b>FNA</b> Site: _____ Transport Media: <input type="checkbox"/> RPMI <input type="checkbox"/> Other _____ (Req. RPMI) Number of TouchPrep Slides Sent: _____	<input type="checkbox"/> <b>Body Fluid</b> Site: <input type="checkbox"/> CSF <input type="checkbox"/> BAL <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Other _____ Transport Media: <input type="checkbox"/> Fresh <input type="checkbox"/> Other _____ (Req. Fresh) Number of TouchPrep Slides Sent: _____
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**TESTING REQUESTED**

**Flow Cytometry:**

Lymphoma Panel    
  Other \_\_\_\_\_    
 Corresponding Specimen Submitted:  
 Tissue    
  FNA    
  Other \_\_\_\_\_

**REFLEX FLOW**    
 Corresponding Case Number: \_\_\_\_\_

**FOR LAB PURPOSES ONLY**

Specimen Description: \_\_\_\_\_ Number of TouchPrep Slides Received: \_\_\_\_\_ ACCESSION #: \_\_\_\_\_









Volume: \_\_\_\_\_ Number of Slides to be Stained: \_\_\_\_\_ DATE/TIME Rec'd: \_\_\_\_\_

Air Dried      Fixed

**Positive Patient Identification: No.**

**Specimen Label Instructions:**

1. Remove the necessary labels and place one (1) label on each specimen container (not on the lid).
2. Please be sure to write in any necessary information on the labels.



**A. Notifier:**

6116 E Warren Ave ● Denver, CO 80222 ● Phone: (303) 512-0888 ● Fax: (303) 512-2246

**B. Patient Name:**

**C. Identification Number:**

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn't pay for the **D. laboratory test(s)** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. laboratory test(s)** below.

D. Laboratory Test(s)	E. Reason Medicare May Not Pay:	F. Estimated Cost
<input type="checkbox"/> Lab Test	Medicare may not consider your diagnosis to be a covered service.	Lab Test \$ _____
<input type="checkbox"/> Cancer Screening	Medicare may not consider your diagnosis to be a covered service.	Estimated Cost \$1200

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. laboratory test(s)** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

- OPTION 1.** I want the **D. laboratory test(s)** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the **D. laboratory test(s)** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the **D. laboratory test(s)** listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.