

PHYSICIAN INFORMATION

PATIENT INFORMATION

Requesting Physician _____ Referring Physician _____

Last Name _____ First Name _____ MI _____

Date of Birth _____ Street Address _____

City _____ State _____ Zip _____

Gender F M _____ () - _____

Chart Number _____ Patient Telephone No. _____

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)

SPECIMEN INFORMATION

Indicate type of specimen and number of tubes _____

Collection Date: _____ Time: _____ Specimen ID #(s): _____

Site of Specimen: _____ Bilateral: Y / N **ICD-9 Code REQUIRED:** _____

Peripheral Blood Green Tops(s) (Na Heparin) _____ Purple Top(s) (EDTA) _____ Yellow Top (ACD) _____ Smears _____

Bone Marrow Green Tops(s) (Na Heparin) _____ Purple Top(s) (EDTA) _____ Yellow Top (ACD) _____ Smears _____ Aspirate _____

*Peripheral Blood or CBC and Smear REQUIRED Core/Biopsy _____ Clot _____ Touch Preps _____ Other _____ Time in B+ _____

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: _____

Meds/Growth Factors: _____

Treatment Status: New Diagnosis Follow-up/Restaging Lymphoma (Type: _____)

AML ALL Myeloma CLL CML MDS Other: _____

Transplant Status: Pre _____ Post _____ (Type: _____ Date: _____) Sex of donor: _____ Cord Blood: Y / N

Diagnostic Assessment and Results over Time (D.A.R.T.)

D.A.R.T. - Approval for Special Studies for Bone Marrow or Peripheral Blood Specimens - The UniPath hematopathologist is to perform morphology as needed and select the appropriate flow cytometry markers, FISH probe(s), molecular test(s), and/or non-routine cytogenetic studies. Results will be correlated by the UniPath Hematopathologist into a synoptic report which will state the final diagnosis.

The UniPath hematopathologist is to contact the submitting physician for approval before ordering any FISH probe(s), molecular test(s), and/or non-routine cytogenetic studies.









INDIVIDUAL STUDIES (Optional)

<input type="checkbox"/> Bone Marrow Morphology <input type="checkbox"/> Blood Morphology* <input type="checkbox"/> Flow Cytometry <input type="checkbox"/> ALL <input type="checkbox"/> AML/Myeloid <input type="checkbox"/> CLL/Lymphoma <input type="checkbox"/> Myeloma <input type="checkbox"/> PNH - peripheral blood only <input type="checkbox"/> ALPS <input type="checkbox"/> Other: _____ <input type="checkbox"/> Microbiology (SPS Yellow Top) <input type="checkbox"/> Mycobacterial smear and culture <input type="checkbox"/> Fungal culture <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cytogenetics <input type="checkbox"/> Routine Chromosome Analysis <input type="checkbox"/> FISH <input type="checkbox"/> AML Panel <input type="checkbox"/> Trisomy 8 <input type="checkbox"/> ALL Panel <input type="checkbox"/> Hyperdiploidy <input type="checkbox"/> MDS Panel <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Myeloma Panel <input type="checkbox"/> CLL Panel <input type="checkbox"/> BCR/ABL t(9,22) <input type="checkbox"/> PML/RARA t(15,17) <input type="checkbox"/> MLL (11q23) <input type="checkbox"/> 5q- <input type="checkbox"/> Monosomy 7 <input type="checkbox"/> Chimerism (for BMT Patients) <input type="checkbox"/> Clone Identification (relapse)	<input type="checkbox"/> Molecular Genetics <input type="checkbox"/> Extract RNA/DNA & Hold <input type="checkbox"/> PML/RARA translocation <input type="checkbox"/> BCR/ABL Rearrangement <input type="checkbox"/> E2A/PBX translocation <input type="checkbox"/> JAK2 V617F <input type="checkbox"/> Kit Mutation Analysis <input type="checkbox"/> B/T Cell Clonality <input type="checkbox"/> B Cell <input type="checkbox"/> T Cell <input type="checkbox"/> B/T Cell <input type="checkbox"/> Other (specify) _____ <div style="border: 1px solid black; padding: 5px; background-color: #ffe0e0;"> For LAB PURPOSES ONLY ACCESSION # _____ DATE/TIME Rec'd. _____ </div>	<input type="checkbox"/> ALL Panel <input type="checkbox"/> AML Panel <input type="checkbox"/> FLT3 <input type="checkbox"/> NPM1 <input type="checkbox"/> CEBP alpha <input type="checkbox"/> STR Markers
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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.

I. Signature:	J. Date:
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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.

Specimen Requirements for Bone Marrow and Peripheral Blood

Specimen Type	Cytogenetics/FISH	Flow Cytometry	Morphology	Molecular ★	Storage & Transport
Bone Marrow Aspirate ☆	Green Top (Sodium Heparin) 1 mL minimum 2-3 mL preferred	Yellow Top (ACD) 1 mL minimum 2-3 mL preferred Green Top OK if Yellow Top is not available	Purple Top (EDTA) 1 mL minimum 2-3 mL preferred	Purple Top (EDTA) 1 mL minimum 2-3 mL preferred (Store Refrigerated)	Ambient Temperature
Peripheral Blood	Green Top (Sodium Heparin) 2-5 mL	Green or Yellow Top 2-5 mL	Purple Top (EDTA) 2-5 mL	Purple Top (EDTA) 2-5 mL (Store Refrigerated)	Ambient Temperature
Bone Marrow Biopsy ☆	1 cm Core if Dry Tap ★	1 cm Core if Dry Tap ★	1.5 cm minimum Core (length) in B+ Fixative Touch preps of core if no aspirate or a poor aspirate is obtained	N/A	Ambient Temperature

☆ **REQUIRED:** Copy of CBC Results and Smear or Purple Top (EDTA)

★ **Molecular needs to be stored refrigerated**

★ **Please Place in RPMI**