labcorp

Testing will be performed at a Labcorp laboratory, including formerly branded Dianon Pathology.

Dianon Systems, Inc
1 Forest Parkway
Shelton, CT 06484
800-328-2666
203-926-7100

LOWER GI TEST REQUISITION

ACCOUNT INFORMATION

ACCOUNT NO. TELEPHONE NO.

ACCOUNT NAME AND ADDRESS

REQUESTING PHYSICIAN (PLEASE PRINT) PHYSICIAN/AUTHORIZED SIGNATURE

REQUESTING PHYSICIAN NPI REFERRING PHYSICIAN

PATIENT INFORMATION

CHART NUMBER PATIENT D.O.B.

PATIENT LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP CODE

SEX M ☐ F ☐

( ) –

RACE MRN / PATIENT ID # PATIENT TELEPHONE NO.

BILLING INFORMATION

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

REQUIRED ICD-CM CODE(S):

BILL: ☐ PRACTICE/FACILITY ☐ PATIENT ☐ MEDICARE ☐ MEDICAID ☐ INSURANCE ☐ REFERRAL # ________

POLICY/ID# ________ GROUP # ________ 2ND INS POLICY/ID# ________ GROUP # ________

INSURANCE CARRIER ________ INSURANCE CARRIER ________

CLAIM ADDRESS ________ CLAIM ADDRESS ________

CITY ________ STATE ________ ZIP ________ CITY ________ STATE ________ ZIP ________

PATIENT HOSPITAL STATUS ☐ INPATIENT ☐ OUTPATIENT ☐ NON-PATIENT

INSURED'S NAME ________ INSURED'S DOB ________

PATIENT'S RELATIONSHIP TO INSURED: ☐ SPOUSE ☐ CHILD ☐ OTHER

CLINICAL DATA (Check all that apply)

- ☐ Bleeding ________
- ☐ Diarrhea (bloody)
- ☐ Diarrhea (watery)
- ☐ Weight loss
- ☐ Pain ________
- ☐ Heme positive stool
- ☐ Family history of cancer (type) ________
- ☐ Personal history of cancer (type) ________
- ☐ Personal history of Colon polyps
- ☐ Personal history of idiopathic inflammatory bowel disease

SPECIAL INDICATIONS

- ☐ Colitis surveillance colonoscopy
- ☐ Polyp/neoplasm surveillance colonoscopy
- ☐ Rule out viral inclusions
- ☐ Rule out parasites
- ☐ Other: ________
- ☐ Rule out idiopathic inflammatory bowel disease
- ☐ Rule out Crohn's
- ☐ Rule out ulcerative colitis
- ☐ Rule out dysplasia
- ☐ Rule out malignancy

SPECIMEN COLLECTION

COLLECTION DATE: ____/____/____

☐ Biopsy ☐ Brushing ☐ Polypectomy
☐ Washing ☐ Other: ________

LYNCH SYNDROME (Complete Biopsy Data Section)

☐ Histology† (Gross & Microscopic Exam) w/Reflex to Lynch Syndrome Comprehensive Tumor Evaluation* if meets Revised Bethesda criteria♦

☐ Histology† (Gross & Microscopic Exam) w/Reflex to Lynch Syndrome Comprehensive Tumor Evaluation* if carcinoma or tubular adenoma at <40

*Includes MLH1/MSH2/MSH6/PMS2 by IHC and/or MSI by PCR. If MLH1 is deficient, reflex to BRAF Gene Mutation; if negative, reflex to MLH1 Promoter Methylation#

♦ Revised Bethesda guidelines for testing colorectal tumors for MSI: Colorectal cancer diagnosed in a patient who is <50 years of age, or Colorectal cancer with the MSI-H histology diagnosed in a patient who is <60 years of age

Lynch Syndrome Eval performed/billed by Labcorp's Oncology division.

ENDOSCOPIC CODES

Please write the applicable number(s) for each corresponding biopsy specimen in the next section below. DO NOT CIRCLE NUMBERS

1 Erosion	6 Normal	11 Stricture
2 Erythema	7 Polyp	12 Ulcer
3 Granularity	8 Polyposis	
4 Mass	9 Pseudomembrane	
5 Nodularity	10 Other ________	

BIOPSY DATA

☐ HISTOLOGY† (Gross and Microscopic Examination)
☐ Consultation† Referred slides ***(Send pathology report)***
☐ Consultation† Referred material requiring slide prep ***(Send pathology report)***

SPECIMEN #	From		Ileum	Ileo Cecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Anastamosis	Proximal	Mid	Distal	ENDOSCOPIC FINDINGS (See codes above)
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	________														____ , ____

BODY SITE (Check only one); DESCRIPTOR (Check only one)

CYTOLOGY DATA

SPECIMEN #	From		Ileum	Ileo Cecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Proximal	Mid	Distal	ENDOSCOPIC FINDINGS (See codes above)
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____	cm	________													____ , ____

BODY SITE (Check only one); DESCRIPTOR (Check only one)

OTHER TESTS

When ordering tests for which Medicare or Medicaid reimbursements will be sought, physicians should order only those tests that are medically necessary for the diagnosis or treatment of the patient.
†Separately billable stains may be added by pathologist when medically necessary to render a diagnosis.

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Refer to Determining Necessity of ABN Completion on reverse.

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Test Combination/Panel Policy

B-1A

Labcorp's policy is to provide physicians, in each instance, with the flexibility to choose appropriate tests to assure that the convenience of ordering test combinations/panels does not distance physicians who wish to order a test combination/profile from making deliberate decisions regarding which tests are truly medically necessary. All the tests offered in test combinations/panels may be ordered individually using the Labcorp request form. Labcorp encourages clients to contact their local Labcorp representative or Labcorp location if the testing configurations shown here do not meet individual needs for any reason, or if some other combination of procedures is desired.

In an effort to keep our clients fully informed of the content, charges and coding of its test combinations/panels when billed to Medicare, we periodically send notices concerning customized test combinations/panels, as well as information regarding patient fees for all Labcorp services. We also welcome the opportunity to provide, on request, additional information in connection with our testing services and the manner in which they are billed to physicians, health care plans, and patients.

The CPT code(s) listed are in accordance with the current edition of *Current Procedural Terminology*, a publication of the American Medical Association. CPT codes are provided for the convenience of our clients; however, correct coding often varies from one carrier to another. Consequently, the codes presented here are intended as general guidelines and should not be used without confirming with the applicable payor that their use is appropriate in each case. All laboratory procedures will be billed to third-party carriers (including Medicare and Medicaid) at fees billed to patients and in accordance with the specific CPT coding required by the carrier. Microbiology CPT code(s) for additional procedures such as susceptibility testing, identification, serotyping, etc. will be billed in addition to the primary codes when appropriate. Labcorp will process the specimen for a Microbiology test based on source.

Determining Necessity of Advance Beneficiary Notice of Non-coverage (ABN) Completion*

1. **Diagnose.** Determine your patient's diagnosis.
2. **Document.** Write the diagnosis code(s) on the front of this requisition.
3. **Verify.** Determine if the laboratory test(s) ordered for the patient is subject to Local Coverage Determination or National Coverage Determination. This information can be located in the policies published by your Medicare Administrative Contractor (MAC), CMS, or www.Labcorp.com/MedicareMedicalNecessity.
4. **Review.** If the diagnosis code for your patient **does not** meet the medical necessity requirements set forth by Medicare or the test(s) is being performed more frequently than Medicare allows, an ABN should be completed.

*An ABN should be completed for all tests that are considered investigational (experimental or for research use) by Medicare.

How to Complete an Advance Beneficiary Notice of Non-coverage (ABN)

Medicare is very specific in requiring that all of the information included on the ABN be completed. Additionally, Labcorp requests that the specimen number or bar code label be included on the form. To be valid an ABN must:

1. Be executed on the CMS approved ABN form (CMS-R-131)
2. Identify the Medicare Part B Beneficiary, using the name as it appears on the patient's red, white and blue Medicare card
3. Indicate the test(s)/procedure(s) which may be denied within the relevant reason column
4. Include an estimated cost for the test(s)/procedure(s) subject to the ABN
5. Have 'Option 1', 'Option 2', or 'Option 3' designated by the beneficiary
6. Be signed **and** dated by the beneficiary or his/her representative **prior to** the service being rendered

Symbols used to designate Medicare medical review as of 10/01/2020

@ = Subject to Medicare medical necessity guidelines.
% = Subject to Medicare frequency guidelines.
# = Medicare deems investigational. Medicare does not pay for services it deems investigational.

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