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

GI PATHOLOGY SERVICES TEST REQUISITION

ACCOUNT INFORMATION

ACCOUNT NO. TELEPHONE NO.

ACCOUNT NAME AND ADDRESS

REQUESTING PHYSICIAN (PLEASE PRINT) ______ PHYSICIAN/AUTHORIZED SIGNATURE ______

REQUESTING PHYSICIAN NPI ______ REFERRING PHYSICIAN (PLEASE PRINT) ______

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

SPECIMEN COLLECTION

METHOD/SPECIMEN ☐ BIOPSY ☐ WASHING ☐ BRUSHING ☐ POLYPECTOMY ☐ OTHER ______ COLLECTION DATE: ____/____/____

ENDOSCOPIC CODES

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

1 EROSION	4 MASS	7 POLYP	10 STRICTURE	13 HIATAL HERNIA
2 ERYTHEMA	5 NODULARITY	8 POLYPOSIS	11 ULCER	14 OTHER ______
3 GRANULARITY	6 NORMAL	9 PSEUDOMEMBRANE	12 BARRETT'S MUCOSA	

UPPER GI

CLINICAL DATA (Check all that apply)

☐ BLEEDING ______ ☐ ANOREXIA ☐ REFLUX
☐ DYSPHAGIA ☐ NAUSEA ☐ WEIGHT LOSS
☐ HEARTBURN ☐ NSAID USAGE ☐ DYSPEPSIA
☐ HEME POSITIVE STOOL ☐ DIARRHEA
☐ PAIN ______
☐ IRON DEFICIENT ANEMIA
☐ PERSONAL HISTORY OF CANCER ______
☐ PERSONAL HISTORY OF LYMPHOMA
☐ HISTORY OF *H. pylori*
☐ HISTORY OF BARRETT'S ESOPHAGUS
☐ Other: ______

SPECIAL INDICATIONS

☐ Rule Out Barrett's Esophagus ☐ Rule Out Fungi
☐ Rule Out Dysplasia ☐ Rule Out Viral Inclusions
☐ Rule Out H. *pylori* ☐ Rule Out Reflux Esophagitis
☐ Rule Out Celiac Disease ☐ Rule Out Eosinophilic Esophagitis
☐ Rule Out Giardia
☐ Other: ______

OTHER TESTS (see reverse for CPT Codes Billed)

☐ 180836 H. *pylori* Urea Breath Test 1-hour Fast? ☐ Yes ☐ No
☐ 180764 H. *pylori* Stool Antigen
☐ 511345 Hereditary Hemochromatosis, DNA Analysis
☐ 550123 HCV FibroSure® @%
☐ 550960 NASH FibroSure® Plus @%*
☐ 550180 ASH FibroSure® @%*
* Required for ASH/NASH:
Fasting at least 8 hours? ☐ Yes ☐ No Height ______ (ins) Weight ______ (lbs)
☐ Other: ______

UPPER GI TEST REQUEST†

☐ HISTOLOGY (Gross & Microscopic)
☐ CYTOLOGY
☐ CONSULTATION: On referred slides (Send pathology report)
☐ CONSULTATION: On referred material requiring slide prep (Send pathology report)

† Separately billable stains may be added by pathologist when medically necessary to render a diagnosis.

ESOPHAGUS

SPECIMEN #	From	TYPE: BIOPSY	BRUSHING	WASHING	OTHER ___	BODY SITE/DESCRIPTOR: Eso Prox.	Eso Mid	Eso Distal	E.G. Junct.	ENDOSCOPIC FINDINGS (See codes above)
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____

STOMACH / DUODENUM

SPECIMEN #	TYPE: BIOPSY	BRUSHING	WASHING	OTHER ___	BODY SITE/DESCRIPTOR: Cardia	Fundus/Body	Antral-Body Transition	Antrum	Duodenum (Bulb)	Duodenum (proximal) / Small Bowel	Anastomosis	ENDOSCOPIC FINDINGS (See codes above)
____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____

LOWER GI

CLINICAL DATA (Check all that apply)

☐ BLEEDING ______ ☐ FAMILY HISTORY OF CANCER (TYPE) ______
☐ DIARRHEA (BLOODY)
☐ DIARRHEA (WATERY) ☐ PERSONAL HISTORY OF CANCER (TYPE) ______
☐ WEIGHT LOSS ☐ PERSONAL HISTORY OF COLON POLYPS
☐ PAIN ______ ☐ PERSONAL HISTORY OF IDIOPATHIC INFLAMMATORY BOWEL DISEASE
☐ HEME POSITIVE STOOL

SPECIAL INDICATIONS

☐ COLITIS SURVEILLANCE COLONOSCOPY ☐ RULE OUT IDIOPATHIC INFLAMMATORY BOWEL DISEASE
☐ POLYP/NEOPLASM SURVEILLANCE COLONOSCOPY ☐ RULE OUT CROHN'S
☐ RULE OUT VIRAL INCLUSIONS ☐ RULE OUT ULCERATIVE COLITIS
☐ RULE OUT PARASITES ☐ RULE OUT DYSPLASIA
☐ RULE OUT MICROSCOPIC COLITIS ☐ RULE OUT MALIGNANCY
☐ OTHER:

BIOPSY/EXCISION DATA

☐ ANAL FISSURE
☐ ANAL FISTULA
☐ ANAL TAG
☐ APPENDECTOMY (NON-INCIDENTAL)
☐ CHOLECYSTECTOMY
☐ HEMORRHOIDS
☐ LIVER BIOPSY

OTHER TESTS

LOWER GI TEST REQUEST†

☐ HISTOLOGY (Gross & Microscopic)
☐ CYTOLOGY – BRUSHING
☐ CYTOLOGY – WASHING
☐ CYTOLOGY – OTHER ______
☐ CONSULTATION: On referred slides (Send pathology report)
☐ CONSULTATION: On referred material requiring slide prep (Send pathology report)
☐ Histology† (Gross & Microscopic Exam) with Reflex to Lynch Syndrome Comprehensive Tumor Evaluation* if meets Revised Bethesda criteria♦
☐ Histology† (Gross & Microscopic Exam) with 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#

SPECIMEN #	From	BODY SITE: Ileum	Illeocecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Anastomosis	DESCRIPTOR: Proximal	Mid	Distal	ENDOSCOPIC FINDINGS (See codes above)
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____ , ____
____	____ cm	______														____ , ____

Refer to Determining Necessity of ABN Completion on reverse.
@ = Subject to Medicare medical necessity guidelines
% = Subject to Medicare frequency guidelines
 # = Medicare deems investigational

When ordering tests for which Medicare or Medicaid reimbursement will be sought, physicians should order only those tests that are medically necessary for the diagnosis or treatment of the patient.

Lynch Syndrome Eval performed and billed by Labcorp Oncology.

WHITE COPY TO DIANON PINK COPY TO PHYSICIAN

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CT Lic. #: CL-0356

1A 1B

Jar 1 Site ____ Name ____	Jar 2 Site ____ Name ____	Jar 3 Site ____ Name ____	Jar 4 Site ____ Name ____		
Jar 5 Site ____ Name ____	Jar 6 Site ____ Name ____	Jar 7 Site ____ Name ____	Jar 8 Site ____ Name ____		
Jar 9 Site ____ Name ____	Jar 10 Site ____ Name ____	Jar 11 Site ____ Name ____	Jar 12 Site ____ Name ____		
Jar 13 Site ____ Name ____	Jar 14 Site ____ Name ____	Jar 15 Site ____ Name ____	Jar 16 Site ____ Name ____		
Jar 17 Site ____ Name ____	Jar 18 Site ____ Name ____	Jar 19 Site ____ Name ____	Jar 20 Site ____ Name ____		
Jar 21 Site ____ Name ____	Jar 22 Site ____ Name ____	Jar 23 Site ____ Name ____	Jar 24 Site ____ Name ____		

Labeling Instructions

1. Complete all requested information on requisition form.
2. Place the indicated label on the corresponding specimen jar. Use one label per specimen.
3. ***Discard all unused labels.***

For Questions, Contact Client Services at 1-800-328-2666.

B-1A

Test Combination/Panel Policy

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.

H. pylori Urea Breath Test — **Test No. 180836**
CPT Code: 83013

H. pylori Stool Antigen — **Test No. 180764**
CPT Code: 87338

HCV FibroSure® — **Test No. 550123**
CPT Codes: 81596

When ordered Individually use Test No.	Components	CPT Code(s)
122135	Alpha-2 Macroglobulin	83883
001628	Haptoglobin	83010
016873	Apolipoprotein A-1	82172
001099	Bilirubin, Total	82247
001958	GGT %@	82977
001545	ALT (SGPT)	84460

Hereditary Hemochromatosis, DNA Analysis — **Test No. 511345**
CPT Code: 81256

NASH FibroSure® — **Test No. 550960**
CPT Codes: 83883, 83010, 82172, 82247, 82977, 84460, 82465, 84478, 82947, 84450

When ordered Individually use Test No.	Components	CPT Code(s)
122135	Alpha-2 Macroglobulin	83883
001628	Haptoglobin	83010
016873	Apolipoprotein A-1	82172
001099	Bilirubin, Total	82247
001958	GGT %@	82977
001545	ALT (SGPT)	84460
001065	Cholesterol, Total %@	82465
001172	Triglycerides %@	84478
001032	Glucose %@	82947
001123	AST (SGOT)	84450

ASH FibroSure® — **Test No. 550180**
CPT Codes: 83883, 83010, 82172, 82247, 82977, 84460, 82465, 84478, 82947, 84450

When ordered Individually use Test No.	Components	CPT Code(s)
122135	Alpha-2 Macroglobulin	83883
001628	Haptoglobin	83010
016873	Apolipoprotein A-1	82172
001099	Bilirubin, Total	82247
001958	GGT %@	82977
001545	ALT (SGPT)	84460
001065	Cholesterol, Total %@	82465
001172	Triglycerides %@	84478
001032	Glucose %@	82947
001123	AST (SGOT)	84450

- 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.

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 01/01/2024

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

Dianon Systems, Inc. is a subsidiary of Laboratory Corporation of America Holdings, using the brand Labcorp

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