Thyroid / FNA Requisition

GOPATH LABORATORIES
Global Pathology Services

MOLECULAR ONCOLOGY
1351 Barclay Blvd, Buffalo Grove, IL 60089
Tel: 855.467.2849; Fax: 224.588.9941
www.gopathlabs.com

PATIENT INFORMATION (Please print)

Name (Last, First) _____
Address _____
City, State, Zip _____
Female ☐ Male ☐ Date of Birth (M/D/Y) _____
SSN# (Optional) _____
Phone# _____
Diagnosis: _____
_____

ORDERING PHYSICIAN / LAB INFORMATION (Please print)

Facility Name _____
Name (Last, First) _____
Address _____
City, State, Zip _____
Phone# _____ Fax# _____ E-Mail: _____
Ordering Physician _____ (M/D/Y) _____
NPI#: _____ Treating Physician: _____
Report Delivery: Fax ☐ E-Mail ☐ Mail ☐ Website Only ☐

CODING INFORMATION

Diagnosis Code/ICD-10 Code: _____

The physician is required to document all applicable ICD codes or descriptions for all tests ordered supporting medical necessity which shall be used in patient plan of care. Example: ICD-10: V16.0 (Family Hx of GI cancer)

COMMON ICD-10 CODES

D34: Benign neoplasm of thyroid gland
D44.0: Neoplasm of uncertain behavior of thyroid gland
D44.9: Neoplasm of uncertain behavior of unspecified endocrine gland
E01.0: Iodine-deficiency related diffuse (endemic) goiter
E01.1: Iodine-deficiency related multinodular (endemic) goiter
E01.2: Iodine-deficiency related (endemic) goiter, unspecified
E04.0: Nontoxic diffuse goiter
E04.1: Nontoxic single thyroid nodule
E04.2: Nontoxic multinodular goiter
E04.8: Other, specified nontoxic goiter
E04.9: Nontoxic goiter, unspecified

BILLING INFORMATION (Please provide copy of insurance card)

Primary Insurance: _____
Bill: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Hospital ☐ Client ☐ Self Pay
Secondary Insurance: ☐ Yes ☐ No *If yes, please attach secondary insurance form*
Secondary Insurance: _____
Place of Service:
☐ 21 - Inpatient Hospital ☐ 22 - Outpatient Hospital ☐ 24 - Ambulatory Surgery Ctr

SPECIMEN INFORMATION (Do not freeze - all specimens must be labeled)

Pathology Department: _____
Phone#: _____ Fax#: _____
Specimen Block ID/#: _____
Collection Date(M/D/Y): _____
Type: ☐ Slides ☐ Block Archived Specimen ☐
Body Site: _____ Primary ☐ Metastatic ☐

CLINICAL HISTORY

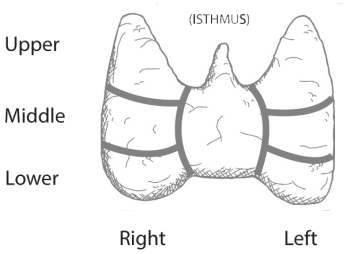
☐ History of cancer, please specify:
_____
_____
_____

☐ Family History of thyroid cancer, please specify:
_____
_____
_____

Suspicious Ultrasound characteristics, specify
☐ Hypoechoic
☐ Irregular border
☐ Microcaldifications
☐ Intranodular vascular pattern
☐ Other:
_____
_____
_____
_____
_____
_____

THYROID DIAGRAM

Location



A Size:_____cm
B Size:_____cm
C Size:_____cm

* Please write letter correlated with nodule location based on ultrasound.

Notes:
_____
_____
_____
_____
_____
_____

REQUIRED TESTS

MOLECULAR ONCOLOGY

☐ ***ThyroiNow:* Digital Droplet PCR Testing** (BRAF, KRAS, NRAS)

Individual Markers (or add to driver panel)
☐ BRAF ☐ KRAS ☐ NRAS

CYTOPATHOLOGY

☐ Cytology Interp, FNA
☐ Cytology Interp, FNA reflex to ***ThyroiNow*** (if IND)
☐ Cytology Interp, FNA with reflex to BRAF ddPCR (if IND)
☐ Cytology Second Opinion, FNA
☐ Other: _____

SPECIMEN REQUIREMENTS

- FNA samples are freshly collected and approximately 500 µl can be placed in the FNA collection tube containing 700 µl of ThinPrep® Cytolyt Solution (Hologic Inc.) provided by GoPath Laboratories. DO NOT overfill the collection tube.
- Ship specimen at room temperature within 24-48 hours.
- Include patient's personal & insurance information.
- Enclose this completed requisition along with the specimen sample.

SPECIAL INSTRUCTIONS

A signature certifies that he/she is licensed to order the test(s) listed above ***and that tests ordered are necessary for the treatment of the above patient.*** **Authorized Signature:** **Date:**

To view reports, please visit www.gopathlabs.com and click Online Reporting.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ 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.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

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.** _____ 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.** _____ 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.** _____ 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.** _____ 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: