BarreGEN™
ESOPHAGEAL CANCER RISK CLASSIFIER

TEST REQUISITION B

Fax completed requisition to: 888-674-6894 | **Client Services: 844-227-7621 | labsupport@interpacediagnostics.com**

For additional information, please contact Client Services

CLINICAL REPORTS

TEST REPORTS SUBMITTED FOR THIS CASE:

☐ PATHOLOGY REPORT ☐ OTHER: _____

☐ ENDOSCOPY REPORT

SUBMITTING DIAGNOSIS

ICD CODES (REQUIRED):

_____ _____ _____

Please indicate ALL applicable diagnosis codes above. Possible codes for your consideration are listed below. DO NOT CIRCLE.

K22.70 Barrett's Esophagus without dysplasia
K22.710 Barrett's Esophagus with low grade dysplasia
K22.719 Barrett's Esophagus with uspecified dysplasia
D37.8 Neoplasm of uncertain behavior of esophagus
D49.0 Neoplasm of unspecified behavior of digestive system

THE DIAGNOSIS CODE(S) PROVIDED SHOULD ALWAYS BE BASED UPON WHAT CAN BE SUPPORTED WITHIN THE PATIENT'S MEDICAL RECORD. TESTING CANNOT BE DONE UNLESS ICD CODE(S) ARE INCLUDED.

BARRETT'S ESOPHAGUS SPECIMEN INFORMATION

COLLECTION DATE _____ (MM/DD/YYYY) TIME _____ (HH:MM) ☐ AM ☐ PM

SPECIMEN COLLECTION SETTING

☐ HOSPITAL (INPATIENT): Date of Discharge _____ (MM/DD/YYYY)

☐ HOSPITAL (OUTPATIENT) ☐ NON-HOSPITAL AFFILIATED SETTING

----SAMPLE 1 ----------

SPECIMEN DESCRIPTION _____

_____

PATHOLOGY No. _____

☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)

#_____STAINED #_____UNSTAINED

----SAMPLE 2 ----------

SPECIMEN DESCRIPTION _____

_____

PATHOLOGY No. _____

☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)

#_____STAINED #_____UNSTAINED

REQUIRED FOR MEDICARE PATIENTS

If this test is ordered more than 14 days after discharge, you must identify factors that affected the time of ordering the test.

REASON CODES

☐ 1. COMPLEX CASE required extensive review and deliberation

☐ 2. INCONCLUSIVE DIAGNOSIS after initial workup; molecular studies ordered for additional data

☐ 3. REVIEW OF INITIAL TEST RESULTS WITH PATIENT required prior to ordering additional studies

☐ 4. CONSULTATION WITH OTHER PHYSICIAN(S) required time to schedule and obtain their input

☐ 5: OTHER: _____

PATIENT INFORMATION (may adhere patient label)

PATIENT NAME _____ (Last Name, First, MI)

DATE OF BIRTH _____ (MM/DD/YYYY) SEX: ☐ FEMALE ☐ MALE

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____ SSN or MRN _____

☐ PATIENT'S DEMOGRAPHIC INFORMATION ATTACHED (FACE SHEET)

BILLING INFORMATION

☐ PATIENT BILLING INFORMATION ATTACHED (Face Sheet, Photocopies of Cards, etc)

BILL TO:

☐ MEDICARE ☐ PRIVATE INSURANCE ☐ ORDERING INSTITUTION

☐ MEDICAID ☐ PATIENT PRE-PAY (US check, cert. funds, etc.)

INSURANCE NAME _____

POLICY # _____ GROUP # _____

POLICY HOLDER NAME _____

DATE OF BIRTH _____ (MM/DD/YYYY)

INTERPACE DIAGNOSTICS WILL BILL DIRECTLY FOR COVERED PATIENTS, WHEREVER PERMITTED BY GOVERNMENT REGULATIONS, PAYER BILLING POLICIES, OR CONTRACTUAL ARRANGEMENTS. IF PATIENT OR INSURANCE INFORMATION IS NOT COMPLETED OR ATTCHED, YOUR FACILITY WILL BE BILLED.

PROVIDER INFORMATION

ORDERING INSTITUTION: _____

_____

_____

COLLECTING INSTITUTION: _____

_____

ORDERING PHYSICIAN(S): NPI TEL FAX

FAX ADD'L REPORTS TO: _____

SIGNATURE

Order BarreGen by signing and dating this section.

I hereby certify that the request for the above test for which reimbursement from Medicare, or third-party payors, will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also authorize providing this patient's test results to the patient's third-party payor. I certify that the patient or referring physician has given consent to the test I have ordered.

PHYSICIAN SIGNATURE _____

PRINT NAME _____ DATE SIGNED _____ (MM/DD/YYYY)

STAFF CONTACT _____

PHONE _____ FAX _____