H

Code 128

00000000

REFERRED BY

ProPath®

1355 RIVER BEND DRIVE
DALLAS, TX 75247
(214) 638-2000
(214) 237-1731 Fax
1-800-258-1253
www.propath.com

Outside box represents Quiet Zone
Code 128

PATIENT INFORMATION — PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (M.I.)

ADDRESS APT. #

CITY STATE ZIP

(AREA CODE) PHONE | BIRTH DATE | SEX

PATIENT S.S. # | PATIENT I.D. #

BILL TO: ❑ **Account** ❑ **Patient (Self Pay)** ❑ **Medicare** ❑ **Medicaid** ❑ **Insurance** ***Please submit a copy of ID card (front and back)**
(Check one) ❑ **Inpatient (Discharge Date_____)** ❑ **Outpatient.**
PLEASE NOTE: Technical Component of services for Hospital-registered Medicare, Medicaid, and Tricare patients will be billed to the Hospital.

INSURANCE COMPANY NAME (attach card) | EMPLOYER NAME

NAME OF INSURED | INSURED POLICY / MEMBER ID # | INSURED'S GROUP #

RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

Referring Physician_____ NPI _____

DATE AND TIME COLLECTED

AM PM

Send Duplicate Report To:

Name_____

Address_____

City/State/Zip_____

MEDICARE PATIENTS ONLY

Must complete Advance Beneficiary Notice (ABN) on back of the first copy of this requisition.

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE | DIAGNOSIS CODE | DIAGNOSIS CODE

CLINICIAN ACKNOWLEDGEMENT (Required)

I attest that I am authorized to order the test(s) and that the ordered test(s) is/are medically necessary for my patient.

CLINICIAN SIGNATURE DATE ORDERED

HEMATOPATHOLOGY REQUISITION

SPECIMEN / CLINICAL INFORMATION

COPY OF CBC AND PATIENT HISTORY SHOULD BE PROVIDED

Clinical History / Diagnosis (Please attach recent summary of patient history or notes from recent clinic visit) _____

Indicate type of specimen and # of tubes below

Blood Green Top(s):_____ Purple Top(s):_____ Smears:_____ Bone Marrow Green Top(s):_____ Purple Top(s):_____ Core Biopsy:_____ Clot:_____ Smears:_____
Touch Preps:_____ Other: _____

❑ ProPath Comprehensive Evaluation

Includes blood/bone marrow morphology, flow cytometry, cytogenetics, FISH, molecular diagnostics, and special and immunohistochemical stains as the ProPath hematopathologist deems medically necessary for a comprehensive diagnosis. PLEASE MAKE SURE ALL THREE ANTICOAGULANT TUBES CONTAIN SUFFICIENT (2-3 ml/tube) MARROW ASPIRATE.

INDIVIDUAL TESTS

Morphology
- ❑ Bone Marrow Morphology
- ❑ Hematopathology Consultation for second opinion

Flow Cytometry
- ❑ Comprehensive Leukemia/Lymphoma
- ❑ PNH, with FLAER

Molecular Diagnostics
- ❑ JAK2 V617F
- ❑ JAK2 V617F reflex to JAK2 Exon 12
- ❑ JAK2 V617F reflex to JAK2 Exon 12, MPL and CALR
- ❑ JAK2 Exon 12
- ❑ MPL W515L/K Mutation Detection
- ❑ CALR
- ❑ FLT3
- ❑ NPM1
- ❑ KIT D816 (Mastocytosis)
- ❑ c-KIT (AML)
- ❑ CEBPA
- ❑ MYD88
- ❑ T-Cell Clonality Assessment by TCR-Gamma PCR
- ❑ B-cell Clonality Assessment by IgH PCR
- ❑ IgVH Immunoglobulin Heavy-chain Variable-region (CLL)
- ❑ IDH 1/2
- ❑ BCR/ABL1 t(9;22) Quantitative Assay for CML

Cytogenetics/FISH
- ❑ Cytogenetics, Karyotyping
- ❑ Cytogenetics with reflex FISH as necessary (indicate probes below)
- ❑ FISH (Indicate probes below)

For single probe(s), check the individual probe boxes. For all probes in a panel, check the panel box.

❑ **MDS/AML Panel**
- ❑ Deletion 5q/Monosomy 5
- ❑ Deletion 7q/Monosomy 7
- ❑ t(8;21), trisomy 8 - RUNX1T1/RUNX1
- ❑ KMT2A (MLL) Rearrangement - 11q23
- ❑ t(15;17) - PML/RARα
- ❑ inv(16) - CBFβ
- ❑ 17p13.1 - TP53
- ❑ Deletion 20q

❑ **Eosinophilia Panel**
- ❑ FIP1L1/CHIC2/PDGFRA, Deletion 4q12
- ❑ PDGFRB Rearrangement - 5q33
- ❑ FGFR1 Rearrangement - 8q21
- ❑ JAK2 – 9p24.1
- ❑ BCR/ABL1

Chronic Myeloid Leukemia
- ❑ BCR/ABL1 rearrangement - t(9;22)

❑ **Large B-Cell Lymphoma Panel**
- ❑ BCL6 Rearrangements - 3q27
- ❑ MYC Rearrangements - 8q24
- ❑ MYC/IGH t(8;14)
- ❑ BCL2 Rearrangements - 18q21
  Reflex to IGH/BCL2 - t(14;18)

❑ **CLL Panel**
- ❑ Deletion 6q - MYB
- ❑ Deletion 11q22.3 - ATM
- ❑ Trisomy 12
- ❑ Deletion 13q/Monosomy 13
- ❑ IGH rearrangement - 14q32; reflex to CCND1/IGH, IGH/BCL2
- ❑ 19q13.2 rearrangements - BCL3
- ❑ 17p13.1 - TP53

❑ **Myeloma Panel**
- ❑ Deletion 1p/1q Gain
- ❑ Trisomy 5, 9, 15
- ❑ Deletion 13q/Monosomy 13
- ❑ IGH rearrangement - 14q32; reflex to FGFR1/IGH, CCND1/IGH If 1st reflex neg, reflex to IGH/MAF, CCND3/IGH, IGH/MAFB
- ❑ 17p13.1 - TP53

ALL Panel
- ❑ Trisomy 4, 10, 17
- ❑ BCR/ABL1 rearrangement - t(9;22)
- ❑ KMT2A (MLL) rearrangement - 11q23
- ❑ ETV6/RUNX1 (TEL/AML1) - t(12;21)
- ❑ IGH rearrangement - 14q32

Additional FISH Probes
- ❑ ALK - t(2;5) and variants
- ❑ CDKN2A (p16) - 9p21
- ❑ CCND1/IGH
- ❑ FGFR3/IGH
- ❑ MECOM- 3q26
- ❑ BIRC3 (API)/MALT1 - t(11;18)
- ❑ X/Y for Bone Marrow Transplant
- ❑ IGH/BCL2

(V58 08/20)

Outside box represents Quiet Zone
Code 128

Outside box represents Quiet Zone
Code 128

SPECIMEN REQUIREMENTS – TO SEND A SPECIMEN CALL 800.258.1253 or 214.638.2000

ADDITIONAL NOTES

Specimens should be sent as soon as possible after draw and kept at room temperature.

Always include CBC and clinical history.

Clearly label each tube with patient name and SS# or birth date.

Clearly label each slide with the patient name and date in pencil. Allow slides to air-dry completely before placing in slide holder(s) provided.

SPECIMEN STORAGE

Store at room temperature. **DO NOT** freeze specimens.

SPECIMEN SHIPPING

Ship at room temperature in special mailer.

Please provide only one patient per mailer.

DO NOT INCLUDE PATIENT IDENTIFYING INFORMATION ON THE MAILER. HIPAA regulations prohibit disclosure of confidential patient information.

TEST / TECHNOLOGY	PERIPHERAL BLOOD	PERIPHERAL BLOOD SMEAR	BONE MARROW ASPIRATE	BONE MARROW SMEAR	BONE MARROW TREPHINE IMPRINT	BONE MARROW FIXED CLOT	BONE MARROW FIXED CORE	BONE MARROW FRESH CORE	LYMPH NODES / FRESH TISSUE
Blood Morphology **1**		2 bedside blood smears (Air Dried Only)							
Bone Marrow Morphology **1**		2 bedside blood smears (Air Dried Only)		6 bedside marrow smears (Air Dried Only)	2 air dried imprint preparations from fresh bone marrow core biopsy specimen	In Formalin **4**	Optimal length: 2.0 cm in Formalin **4**		
Blood or Marrow Flow Cytometry **2,3**	7-10 ml in green top (sodium heparin) tube		2-3 ml in green top (sodium heparin) tube					**Call ProPath**	**Call ProPath**
Blood or Marrow Cytogenetics/ FISH **2,3**	7-10 ml in green top (sodium heparin) tube		2-3 ml in green top (sodium heparin) tube					**Call ProPath**	**Call ProPath**
Blood or Marrow Molecular Diagnostics **2,3**	2-3 ml in purple top (EDTA) tube		2-3 ml in purple top (EDTA) tube					**Call ProPath**	**Call ProPath**

1. Smears should be made from non-anticoagulated blood or marrow. FRESH (<1 hour) EDTA (purple top) specimens may be used. SMEARS SHOULD **NEVER** BE MADE FROM HEPARINIZED SPECIMENS AS HEPARIN ADVERSELY AFFECTS MORPHOLOGY.

2. May use fresh core in case of "dry tap" (NO ASPIRATE).

3. May be performed on blood specimen IF blood involved by leukemic cells. Pathologist at ProPath can make this determination.

4. Place Formalin bottles with samples in **SEALED** plastic baggy (included) before putting in the special mailer.

Complete Test Requisition Form. Include patient insurance information and appropriate clinical data. Retain the bottom copy for your records.
To send specimen, call ProPath at 800.258.1253 or 214.638.2000 for pick-up.

ProPath, 1355 River Bend Drive, Dallas, TX 75247 **Client Services: Ph: 800.258.1253 or 214.638.2000, Fax: 214.237.1731 www.propath.com**

FLUORESCENCE IN SITU HYBRIDIZATION (FISH) TESTS

Acute Myeloid Leukemia (AML) / Myelodysplastic Syndromes (MDS) FISH Panel

Detects deletions and other aberrations of chromosomes 5, 7 and 11 (MLL), gain of chromosome 8, deletions in the long arm of 20 and TP53 gene, inv(16) and the t(8;21) and t(15;17) rearrangements.

Chronic Lymphocytic Leukemia / Small Lymphocytic Lymphoma (CLL) FISH Panel

Detects deletions of MYB gene (chromosome 6), ATM gene (chromosome 11), long arm of chromosome 13 and TP53 gene, gain of chromosome 12 and the t(11;14) and t(14;18) rearrangements.

Multiple Myeloma (MM) FISH Panel

Detects gains of chromosomes 5, 9 and 15, deletions of the long arm of chromosome 13 and TP53 gene and the t(11;14) rearrangement.

H

REFERRED BY

ProPath®

1355 RIVER BEND DRIVE
DALLAS, TX 75247
(214) 638-2000
(214) 237-1731 Fax
1-800-258-1253
www.propath.com

PATIENT INFORMATION — PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (M.I.)

ADDRESS APT. #

CITY STATE ZIP

(AREA CODE) PHONE | BIRTH DATE | SEX

PATIENT S.S. # | PATIENT I.D. #

BILL TO: ❑ **Account** ❑ **Patient (Self Pay)** ❑ **Medicare** ❑ **Medicaid** ❑ **Insurance** ***Please submit a copy of ID card (front and back)**
(Check one) ❑ **Inpatient (Discharge Date_____)** ❑ **Outpatient.**
PLEASE NOTE: Technical Component of services for Hospital-registered Medicare, Medicaid, and Tricare patients will be billed to the Hospital.

INSURANCE COMPANY NAME (attach card) | EMPLOYER NAME

NAME OF INSURED | INSURED POLICY / MEMBER ID # | INSURED'S GROUP #

RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

Referring Physician_____ NPI _____

DATE AND TIME COLLECTED

AM PM

Send Duplicate Report To:

Name_____

Address_____

City/State/Zip_____

MEDICARE PATIENTS ONLY

Must complete Advance Beneficiary Notice (ABN) on back of the first copy of this requisition.

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE | DIAGNOSIS CODE | DIAGNOSIS CODE

CLINICIAN ACKNOWLEDGEMENT (Required)

I attest that I am authorized to order the test(s) and that the ordered test(s) is/are medically necessary for my patient.

CLINICIAN SIGNATURE DATE ORDERED

HEMATOPATHOLOGY REQUISITION

SPECIMEN / CLINICAL INFORMATION

COPY OF CBC AND PATIENT HISTORY SHOULD BE PROVIDED

Clinical History / Diagnosis (Please attach recent summary of patient history or notes from recent clinic visit) _____

Indicate type of specimen and # of tubes below

Blood Green Top(s):_____ Purple Top(s):_____ Smears:_____ Bone Marrow Green Top(s):_____ Purple Top(s):_____ Core Biopsy:_____ Clot:_____ Smears:_____
Touch Preps:_____ Other: _____

❑ ProPath Comprehensive Evaluation

Includes blood/bone marrow morphology, flow cytometry, cytogenetics, FISH, molecular diagnostics, and special and immunohistochemical stains as the ProPath hematopathologist deems medically necessary for a comprehensive diagnosis. PLEASE MAKE SURE ALL THREE ANTICOAGULANT TUBES CONTAIN SUFFICIENT (2-3 ml/tube) MARROW ASPIRATE.

INDIVIDUAL TESTS

Morphology
- ❑ Bone Marrow Morphology
- ❑ Hematopathology Consultation for second opinion

Flow Cytometry
- ❑ Comprehensive Leukemia/Lymphoma
- ❑ PNH, with FLAER

Molecular Diagnostics
- ❑ JAK2 V617F
- ❑ JAK2 V617F reflex to JAK2 Exon 12
- ❑ JAK2 V617F reflex to JAK2 Exon 12, MPL and CALR
- ❑ JAK2 Exon 12
- ❑ MPL W515L/K Mutation Detection
- ❑ CALR
- ❑ FLT3
- ❑ NPM1
- ❑ KIT D816 (Mastocytosis)
- ❑ c-KIT (AML)
- ❑ CEBPA
- ❑ MYD88
- ❑ T-Cell Clonality Assessment by TCR-Gamma PCR
- ❑ B-cell Clonality Assessment by IgH PCR
- ❑ IgVH Immunoglobulin Heavy-chain Variable-region (CLL)
- ❑ IDH 1/2
- ❑ BCR/ABL1 t(9;22) Quantitative Assay for CML

Cytogenetics/FISH
- ❑ Cytogenetics, Karyotyping
- ❑ Cytogenetics with reflex FISH as necessary (indicate probes below)
- ❑ FISH (Indicate probes below)

For single probe(s), check the individual probe boxes. For all probes in a panel, check the panel box.

❑ **MDS/AML Panel**
- ❑ Deletion 5q/Monosomy 5
- ❑ Deletion 7q/Monosomy 7
- ❑ t(8;21), trisomy 8 - RUNX1T1/RUNX1
- ❑ KMT2A (MLL) Rearrangement - 11q23
- ❑ t(15;17) - PML/RARα
- ❑ inv(16) - CBFβ
- ❑ 17p13.1 - TP53
- ❑ Deletion 20q

❑ **Eosinophilia Panel**
- ❑ FIP1L1/CHIC2/PDGFRA, Deletion 4q12
- ❑ PDGFRB Rearrangement - 5q33
- ❑ FGFR1 Rearrangement - 8q21
- ❑ JAK2 – 9p24.1
- ❑ BCR/ABL1

Chronic Myeloid Leukemia
- ❑ BCR/ABL1 rearrangement - t(9;22)

❑ **Large B-Cell Lymphoma Panel**
- ❑ BCL6 Rearrangements - 3q27
- ❑ MYC Rearrangements - 8q24
- ❑ MYC/IGH t(8;14)
- ❑ BCL2 Rearrangements - 18q21
  Reflex to IGH/BCL2 - t(14;18)

❑ **CLL Panel**
- ❑ Deletion 6q - MYB
- ❑ Deletion 11q22.3 - ATM
- ❑ Trisomy 12
- ❑ Deletion 13q/Monosomy 13
- ❑ IGH rearrangement - 14q32; reflex to CCND1/IGH, IGH/BCL2
- ❑ 19q13.2 rearrangements - BCL3
- ❑ 17p13.1 - TP53

❑ **Myeloma Panel**
- ❑ Deletion 1p/1q Gain
- ❑ Trisomy 5, 9, 15
- ❑ Deletion 13q/Monosomy 13
- ❑ IGH rearrangement - 14q32; reflex to FGFR1/IGH, CCND1/IGH If 1st reflex neg, reflex to IGH/MAF, CCND3/IGH, IGH/MAFB
- ❑ 17p13.1 - TP53

ALL Panel
- ❑ Trisomy 4, 10, 17
- ❑ BCR/ABL1 rearrangement - t(9;22)
- ❑ KMT2A (MLL) rearrangement - 11q23
- ❑ ETV6/RUNX1 (TEL/AML1) - t(12;21)
- ❑ IGH rearrangement - 14q32

Additional FISH Probes
- ❑ ALK - t(2;5) and variants
- ❑ CDKN2A (p16) - 9p21
- ❑ CCND1/IGH
- ❑ FGFR3/IGH
- ❑ MECOM- 3q26
- ❑ BIRC3 (API)/MALT1 - t(11;18)
- ❑ X/Y for Bone Marrow Transplant
- ❑ IGH/BCL2

(V58 08/20)

A. Notifier: ProPath 1355 River Bend Drive, Dallas, Texas 75247 800.654.1888

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

Advance Beneficiary Notice of Non-coverage (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
Cytogenetics for Bone Marrow Flow Cytometry	Not covered for patient's condition Not covered for patient's condition	$ 900 - $5000 $1300 - $5500

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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.