QDxPathology SERVICES

SPECIMEN ID: T135770

GASTROINTESTINAL TEST REQUISITION

CLIA ID # 31D2026917

PATIENT INFORMATION - ALL REQUIRED

Date of Collection: ____________ Time of Collection: ____________
Last Name: ____________ First Name: ____________ MI: ______
Cell #: ____________ Email: ____________
Home #: ____________ Street Address: ____________
Apt: ________ City: ____________ State: _____ Zip: _________
DOB: (MM/DD/YYYY): _______ / _______ / ____________ SSN #: ____________
(SSN # required for self-pay patients only)

Gender Identity and Sexual Orientation

☐ Male
☐ Female
☐ Non-Binary/Genderqueer
☐ Transgender Male
☐ Transgender Female
☐ Choose not to disclose
☐ Straight or Heterosexual
☐ Lesbian, Gay or Homosexual
☐ Bisexual
☐ Other: ____________

Race and Ethnicity - Select all that apply

☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ White
☐ Choose not to disclose
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Other: ____________

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFO. (Required)

INSURANCE INFO. (Required)

Policyholder Name: ____________
Insurance Name: ____________
Policy #: ____________
Group #: ____________

☐ Bill Insurance
☐ Bill Client
☐ Self Pay
☐ TC/PC

Please provide a copy of the front & back of insurance card(s).

CASE TYPE

☐ Biopsy ☐ Washing ☐ Brushing ☐ Other: ____________ Date: ____ / ___ / ______ Time: __________ Method: ____________

CLINICAL DATA SYMPTOMS, SIGNS AND HISTORY (Check all that apply)

☐ Z12.11 Colon Cancer Screening
☐ R10.9 Abdominal Pain
☐ K25.3 Acute Stomach Ulcers
☐ D64.9 Anemia
☐ R19.4 Change in Bowel Habits
☐ K63.5 Colon Polyp
☐ K59.00 Constipation
☐ K50.90 Crohn's
☐ R19.7 Diarrhea
☐ K30 Dyspepsia
☐ R13.10 Dysphagia
☐ R10.13 Epigastric Pain
☐ Z80.0 Family History of Colon Cancer
☐ K29.70 Gastritis
☐ K21.9 G.E.R.D.
☐ B96.81 H. Pylori Follow-up
☐ R12 Heartburn
☐ R19.5 Occult Blood Loss
☐ A09 Infectious Diarrhea
☐ Z13.811 Lower Gastro Disorder Screening
☐ K90.9 Malabsorption
☐ R11.0 Nausea
☐ R93.3 Non-specific Abdominal finding GI Tract
☐ Personal hx. of Cancer of: ____________
☐ Z85.038 Personal History of Colon Cancer
☐ Z86.010 Personal History of Colon Polyps
☐ K62.5 Rectal Bleeding
☐ K22.70 Surveillance Barrett's
☐ K51.90 Ulcerative Colitis
☐ R11.10 Vomiting
☐ R63.4 Weight Loss
☐ Other: ____________

SPECIAL INDICATIONS/RULE OUT (Check all that apply)

☐ Barrett's Esophagus
☐ Cancer
☐ Colitis Surveillance Colonoscopy
☐ Crohn's
☐ Dysplasia
☐ Eosinophilic Esophagitis
☐ Fungi
☐ Gastritis/H. Pylori
☐ Microscopic Colitis
☐ Parasites
☐ Polyp/Neoplasm Surveillance Colonoscopy
☐ Sprue
☐ Ulcerative Colitis
☐ Virus
☐ Rule Out (Other): ____________

ANATOMIC SITE

UPPER GI Specimen

#	FROM	Esophagus	EG Junction	Fundus	Body	Antrum	Duodenum (Bulb)	Duodenum (Small Bowel)	Liver	Proximal	Distal	Other (Specify)	Biopsy	Polypectomy	Other (Specify)		Findings (See Codes below)
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____

LOWER GI Specimen

#	FROM	Ileum	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Proximal	Mid	Distal	Biopsy	Polypectomy	Other (Specify)		Findings (See Codes below)
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____
____	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____	____ . ____

***Additional charges may apply for ID/Susceptibilities Reflex tests will be performed at additional charge

CODES

Please write the applicable number(s) for each corresponding biopsy specimen in the Anatomic Site section on left (do not circle code numbers).

1. Barrett's Mucosa
2. Corrugated
3. Diminutive Polyp
4. Duodenitis
5. Erosion
6. Erythema
7. Esophagitis
8. Gastritis
9. Granularity
10. H. Pylori
11. Hiatal Hernia
12. Iletis
13. Mass
14. Nodularity
15. Normal
16. Polyp
17. Polyposis
18. Pseudomembrane
19. Pseudopolyps
20. Random Bx
21. Salmon-Colored Mucosa
22. Stricture
23. Submucosal Nodule
24. Ulcer
25. Other: ____________

ADDITIONAL TESTING/NOTES

PROVIDER MUST SIGN TO APPROVE TESTING

Provider Signature: ____________
CMS requires provider signature on all requisitions. QDx Pathology Services is responsible for verifying signature prior to performing testing.

Patient Signature: ____________
I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to QDx Pathology Services and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Notifier(s):

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box 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 items listed or checked in the box below.

Laboratory Tests	Reason Medicare May Not Pay	Estimated Costs

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 checked items listed in the first box 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.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1**: I want the Laboratory Test(s) 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 Laboratory Test(s) 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 do not want the Laboratory Test(s) listed above, I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

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.

Signature:	**Date:**