QDxPathology SERVICES

GPP
Gastrointestinal Pathogen Panel

CLIA ID# 31D2026917

PATIENT INFORMATION (Required)

Date of Collection: _____ Time of Collection: _____
Last Name: _____ First Name: _____
DOB: (MM/DD/YYYY): _____ / _____ / _____ SSN #: _____
(SSN # required for self-pay patients only)
Cell #: _____ Street Address: _____
City: _____ State: _____ Zip: _____

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 Non-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

Please provide a copy of the front & back of insurance card(s)
For shipment of kits to patient, include credit cord info. on bock.

GI Pathogen Panel - PCR (Included pathogens listed on back)

☐ **Gastrointestinal Pathogen Panel (GPP)**

Provider acknowledges that QDx may cancel add-on tests ordered with a GPP that are not medically necessary based on the initial GPP results.

Additional Pathogens - Listed on back, but must complete below ☐

*** Must complete Statement of Medical Necessity * - for additional Pathogens**

- ☐ The patient has immune deficiencies
- ☐ The patient has IBD and unexplained diarrhea
- ☐ The patient has history of recent travel
- ☐ The patient has chronic unexplained diarrhea
- ☐ The patient has community acquired diarrhea of>7 days.
- ☐ The patient has diarrhea with signs or risk factors for severe disease (fever, bloody diarrhea, dysentery, dehydration, severe abdominal pain, hospitalization and/or immune-com promised state).

Additional Stool Assays

- ☐ Calprotectin (EIA) **OR** ☐ Lactoferrin Scan (Quantitative EIA)
- ☐ ASCA-CHEK (EIA)
- ☐ Stool WBC Note: If ordered with above test, provide clinical reasoning.
  Reason: _____
  _____
- ☐ GDH Reflex to Clostridium difficile, Toxin A/B EIA. Order ONLY if GPP (including Clostridium difficile Toxin A/B) is not ordered.
- ☐ Pancreatic Elastase (EIA)*
- ☐ Fecal Fat
- ☐ H. Pylori

*Watery stools may be rejected for Pancreatic Elastase

- ☐ Ova & Parasites

- Additional Requests:

- ☐ Cryptosporidium
- ☐ Cyclospora
- ☐ Pinworm
- ☐ Isospora
- ☐ Microsporidia

Note: Call lab ahead of time for collection container.

ICD-10 Codes

*For Additional Pathogens, an immunosuppression code must be selected. If the appropriate code is not selected, the lab cannot proceed with testing additional pathogens.

Primary diagnosis code:

- ☐ A04.72 C. diff., not specified as recurrent
- ☐ K50.019 Crohn's disease of small intestine w/unspecified complications
- ☐ K51.9 Crohn's disease, unspecified, w/unspecified complications
- ☐ K51.00 Ulcerative (chronic) pancolitis w/o complications
- ☐ K51.919 Ulcerative colitis, unspecified, w/unspecified complications
- ☐ K52.9 Noninfective gastroenteritis and colitis unspecified
- ☐ K58.0 Irritable bowel syndrome w/diarrhea
- ☐ K58.9 Irritable bowel syndrome w/o diarrhea
- ☐ K59.09 Other constipation
- ☐ K59.1 Functional diarrhea
- ☐ R10.0 Acute abdomen
- ☐ R11.2 Nausea with vomiting
- ☐ R19.7 Diarrhea unspecified
- ☐ B80 Enterobiasis
- ☐ K52.3 Chronic IBD
- ☐ K86.81 Exocrine pancreatic insufficiency
- ☐ K90.9 Intestinal malabsorption, unspecified
- ☐ R10.84 Generalized abdominal pain
- ☐ R14.0 Abdominal distention (bloating)
- ☐ R14.1 Gas pain
- ☐ R14.3 Flatulence
- ☐ R19.4 Change in bowel habit
- ☐ R19.5 Occult in blood

Immunosuppression codes:

- ☐ D81.89 Other combined immunodeficiencies
- ☐ D82.8 Immunodeficiency associated w/o specified major defects
- ☐ D83.8 Other common variable immunodeficiencies
- ☐ D84.9 Immunodeficiency, unspecified
- ☐ Other _____

PROVIDER MUST SIGN TO APPROVE TESTING

Medicare patients: Please review and sign ABN on the back.

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.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.qdxpath.com

QDxPathology SERVICES

GI Pathogen Panel (GPP)

Bacteria
Campylobacter (C. jejuni, C. coli)
Clostridium difficile, Toxin A/B (Reflex to C. diff. toxin A/B EIA)
Salmonella
Vibrio spp. (V. vulnificus/V. cholera)
Vibrio parahaemolyticus
Yersinia enterocolitica
Diarrheagenic E. coli/Shigella
- Enteroaggregative E. coli (EAEC)
- Enterotoxigenic E. coli (ETEC) It/st
- Shiga-like toxin-producing E. coli (STEC) stxl/stx2
- E. coli 0157
- Shigella/Enteroinvasive E. coli (EIEC)

Parasites
Giardia lamblia
Entamoeba histolytica

Viruses
Adenovirus F40/41 Astrovirus
Norovirus GI/GII
Rotavirus A

Additional Pathogens - all of the pathogens above plus the 5 below:

Bacteria
Plesiomonas shigelloides
Diarrheagenic E. coli/Shigella
- Enteropathogenic E. coli (EPEC)

Parasites
Cryptosporidium
Cyclospora cayetanensis

Viruses
Astrovirus
Sapovirus (L IL IV, and V)

ABN - Medicare recipients, please review, sign and date

A. QDx Pathology Services, 300 Columbus Circle, Suite A, Edison, NJ 08837, 1-866-845-6842

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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. lab tests** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care providerhave good reason to think you need. We expect Medicare may not pay forthe **lab tests** below.

D. Checked Lab Test(s) Only:	□ GPP (6-11 targets):	$184.09	□ Pancreatic Elastase (EIA):	$8.07
	□ Calprotectin (EIA):	$13.74	□ Ova & Parasites:	$6.23
	□ Lactoferrin (Quant) (EIA):	$13.74	□ w/Trichromestian:	$12.59
	□ ASCA-CHEK (EIA):	$12.09	□ Cryptosporidium Smear:	$4.19
	□ Stool WBC:	$6.61	□ Pinworm:	$3.00
	□ Fecal Fat:	$3.57	□ Modified Acid Fast Stain:	$4.68
	□ H-Pylori for Stool:	$10.07	□ Leukocyte Assess. Fecal:	$2.99
	□ C. Diff Toxins A & B:	$8.39	□ Infectious Agent, Antigen Detection by Immunoassay:	$8.39
	□ Other _____			
E. Reason Medicare May Not Pay:	Medicare does not pay for this test for your condition			
F. Estimated Cost				

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about yourcare.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receive the **D. lab tests** listed above.

Note: If you choose Option 1 or 2, we may help to use another insurance 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. lab tests** 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 aMedicare 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. lab tests** 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. lab tests** 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.

Patient please sign and complete

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.

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