Stanford HEALTH CARE
STANFORD MEDICINE

Anatomic Pathology and Clinical Laboratories
Customer Service Toll Free (877) 717-3733

MOLECULAR PATHOLOGY

For Lab Use Only	Facility Name	Ordering Physician Name Last First
	Address	Physician NPI No.
	City, State, Zip	Physician Phone No. ( )
	Facility Phone Number ( )	Report Fax Number ( )

Patient Name (Last) (First)			Insurance Info: Attach a copy of front & back of Insurance card or face sheet ❑ Private Ins/PPO ❑ Medicare ❑ Medi-Cal ❑ Patient ❑ Client
Unique ID or MRN	DOB-Required	Sex M F	Responsible Party (Please Print)
Patient's Phone Number ( )	Collection Date & Time	Collection by- Required	Address
Copy to: First Name Last Name			City, State, Zip
Copy to complete address for mailing:			**ICD Code(s) - *REQUIRED INFORMATION***
			Physician Signature: Date: Time:

Each individual test and CMS approved panel must have ICD code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD code(s) for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests. Continued on page 3.

SAMPLE TYPE

❑ Peripheral Blood
❑ Bone Marrow Aspirate
■% neoplastic cells in sample submitted_____

❑ Fresh Tissue; site_____ Type _____
❑ Paraffin Block; site _____ Block No. _____
●% tumor in sample submitted_____

❑ Fluid; type_____
❑ Slides; site_____
❑ Slide No._____

CLINICAL HISTORY

Signs/Symptoms:_____
Suspected Diagnosis:_____
Prior Diagnosis_____

MOLECULAR PATHOLOGY

✓	Test Name
❑	Alpha Thalassemia/Hb Constant Spring
❑	AML Prognosis Assay- NMP1 & FLT3 ■
❑	B-Cell Receptor Immunoglobulin Gene Rearrangement by Next Generation Sequencing *(Include pathology report)*
❑	BCR-ABL ◆
❑	BCR-ABL Kinase Domain Mutation Analysis ◆
❑	Beta Thalassemia Sequencing
❑	BRAF by PCR *(Include Pathology report)* ●
❑	Calreticulin Mutation Detection
❑	EGFR Mutation Detection *(Include pathology report)* ●
❑	IDH1/IDH2 Mutation Panel *(Include Pathology report)* ●
❑	KIT D816V *(Include Pathology report)*
❑	Factor V Leiden
❑	Fusion-STAMP Stanford Actionable Mutation Panel for Fusions *(Include pathology report)* ▼
❑	JAK2 V617F (1849G>T), Quantitative
❑	KRAS/NRAS Mutation Detection *(Include pathology report)* ●
❑	STAMP Stanford Solid Tumor Actionable Mutation Panel by Next Gen Seq. *(Include pathology report)* ●▼
❑	MGMT by Methylation Specific PCR ●

✓	Test Name
❑	MYD88 Mutation L265P, 794T>C ■ Check box ❑ if unable to estimate % neoplastic cells
❑	Heme-STAMP Stanford Actionable Mutation Panel for Hematopoietic and Lymphoid Neoplasms ▼
❑	PML-RARα t(15;17),Quant ◆
❑	POLE Mutation Detection Include Pathology Report
❑	Prothrombin-20210A Mutation
❑	SF3B1 Mutation ■ Check box ❑ if unable to estimate % neoplastic cells
❑	T-Cell Receptor Gene Rearrangement by Next Generation Sequencing *(Include pathology report)*
❑	VH Mutation Analysis
❑	Microsatellite Instability by PCR **Check if whole blood submitted** ❑ NOTE: submit a normal block or peripheral blood with tumor sample Include Pathology report●
❑	Extract DNA for future testing
❑	Extract RNA for future testing
❑	Other_____

◆ RNA Studies –ship on wet ice ■ Provide the % neoplastic cells in sample submitted
● Provide the % tumor in sample submitted
▼A full list of targeted regions for the Sequencing Assays can be found at www.stanfordlab.com

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Unique ID or MRN	DOB-Required	Sex M F	Responsible Party (Please Print)
Patient's Phone Number ( )	Collection Date & Time	Collection by- Required	Address
Copy to: First Name	Last Name		City, State, Zip
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SAMPLE TYPE

❑ Peripheral Blood
❑ Fluid; type_____
❑ Fresh Tissue; site_____ Type_____
❑ Paraffin Block; site _____ Block No._____

CLINICAL HISTORY

Signs/Symptoms:_____
Suspected Diagnosis:_____
Prior Diagnosis_____

MOLECULAR PATHOLOGY

✓	Test Name
❑	Alpha Thalassemia/Hb Constant Spring
❑	Beta Thalassemia Sequencing
❑	Biotinidase Sequencing Assay
❑	CF 39, Cystic Fibrosis, DNA
❑	CF Poly-T Analysis
❑	CFTR Screen by Sequencing (Unidirectional)
❑	CFTR Deletion/Duplication Analysis by MLPA
❑	CFTR Diagnostic Sequencing (Bidirectional DNA Full gene)
❑	CFTR Sequencing Assay, Exon specific List mutation(s): _____
❑	Connexin 26, Sequencing
❑	Connexin 30

✓	Test Name
❑	Factor V Leiden
❑	Fragile X
❑	Hemochromatosis Genotyping Analysis
❑	Prothrombin-20210A Mutation
❑	Maternal Cell Contamination-Fetal Sample and Maternal Cell Contamination- *Whole Blood Maternal Sample (4mL EDTA) required with prenatal sample.*
❑	Extract DNA for future testing
❑	Extract RNA for future testing
❑	Other: _____

◆ RNA studies ship on wet ice

STANFORD SPECIMEN REQUIREMENTS

For Specimen collection questions you may call the testing laboratory at the phone number listed next to the department name or contact our Customer Service department at 1-877-717-3733.
Specimen requirements can also be found on www.stanfordlab.com.

MOLECULAR PATHOLOGY	Lab Phone Number (650) 723-6574
Whole Blood	• Minimum 4 mL • Lavender-top (EDTA) tubes • **Provide % neoplastic cells in sample submitted** **RNA Studies –ship on wet ice, DNA Studies ship at room temperature**
Bone Marrow	• 1-2 mL Bone Marrow • Lavender-top (EDTA) tubes • Maintain specimen at room temperature • **Provide % neoplastic cells in sample submitted**
Tissue Enclose a copy of the patient's Pathology Report	• Non-decalcified formalin-fixed, paraffin-embedded (FFPE) at room temperature • **Provide % tumor in sample submitted or H & E stained slide of block submitted**
Fluid	• Volume varies, contact laboratory • Sterile tube • Maintain specimen at room temperature

Ship to:
If shipping Friday check for Saturday delivery
Phone: 1 (877) 717-3733
Fax delivery notification to: (650) 724-4758

Stanford Anatomic Pathology and Clinical Laboratories
Attn: Specimen Processing
3375 Hillview Ave
Palo Alto, CA 94304

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford Health Care Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

Continued from page 1 or 2
Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of any illness or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied.
@ This test is subject to Medicare NCD or LCD, coverage is limited to certain diagnoses that support medical necessity.

Patient's First Name: _____

Patient's Last Name: _____

Patient's MRN: _____

Or Affix Label Here

Stanford HEALTH CARE

STANFORD MEDICINE

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:

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.