

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 | <ul style="list-style-type: none"> • Minimum 4 mL • Lavender-top (EDTA) tubes <p>RNA Studies –ship on wet ice, DNA Studies ship at room temperature ■ Provide % neoplastic cells in sample submitted</p> | |
| Bone Marrow | <ul style="list-style-type: none"> • 1-2 mL Bone Marrow • Lavender-top (EDTA) tubes • Maintain specimen at room temperature <p>■ Provide % neoplastic cells in sample submitted</p> | |
| Tissue <i>Enclose a copy of the patient's Pathology Report</i> | <ul style="list-style-type: none"> • Non-decalcified formalin-fixed, paraffin-embedded (FFPE) at room temperature • Provide % tumor in sample submitted or H & E stained slide of block submitted | |
| Fluid | <ul style="list-style-type: none"> • 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 University Medical Center 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.

* ICD Code(s) based on present CMS guidelines.

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: |
| | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.