

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

Patient Name (Last) (First)		Insurance Info: Attach a copy of front & back of Insurance card or face sheet <input type="checkbox"/> Private Ins/PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Patient <input type="checkbox"/> 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
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Copy to: First Name Last Name	City, State, Zip
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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
- Fresh Tissue; site _____ Type _____
- Paraffin Block; site _____ Block No. _____
- Fluid; type _____
- Slides; site _____
- % neoplastic cells in sample submitted _____
- % tumor in sample submitted _____
- Slide No. _____

CLINICAL HISTORY

Signs/Symptoms: _____ Prior Diagnosis _____
Suspected Diagnosis: _____

MOLECULAR PATHOLOGY

- | | |
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| <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Test Name <input type="checkbox"/> Alpha Thalassemia/Hb Constant Spring <input type="checkbox"/> AML Prognosis Assay- NMP1 & FLT3 ■ <input type="checkbox"/> B-Cell Clonality <i>Include Pathology report</i> <input type="checkbox"/> BCR-ABL ◆ <input type="checkbox"/> BCR-ABL Kinase Domain Mutation Analysis ◆ <input type="checkbox"/> Beta Thalassemia Sequencing <input type="checkbox"/> BRAF by PCR <i>Include Pathology report</i> ● <input type="checkbox"/> Calreticulin Mutation Detection <input type="checkbox"/> CEBPA by sequencing ■ <input type="checkbox"/> IDH1/IDH2 Mutation Panel <i>Include Pathology report</i> ● <input type="checkbox"/> KIT Mutation Analysis(exons 8 & 17) ◆■ <input type="checkbox"/> KIT D816V <i>Include Pathology report</i> <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> JAK2 V617F (1849G>T), Quantitative <input type="checkbox"/> KRAS/NRAS Mutation Detection <i>Include Pathology report</i> ● <input type="checkbox"/> STAMP Stanford Solid Tumor Actionable Mutation Panel by Next Gen Seq. <i>Include Pathology report</i> ● ▼ <input type="checkbox"/> MGMT by Methylation Specific PCR ● <input type="checkbox"/> MYD88 Mutation L265P, 794T>C ■ Check box <input type="checkbox"/> if unable to estimate % neoplastic cells | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Test Name <input type="checkbox"/> Heme-STAMP Stanford Actionable Mutation Panel for Hematopoietic and Lymphoid Neoplasms <input type="checkbox"/> PML-RARα t(15;17),Quant ◆ <input type="checkbox"/> POLE Mutation Detection <i>Include Pathology report</i>" under PML <input type="checkbox"/> Prothrombin-20210A Mutation <input type="checkbox"/> SF3B1 Mutation ■ Check box <input type="checkbox"/> if unable to estimate % neoplastic cells <input type="checkbox"/> T-Cell Clonality by PCR/NGS <i>Include Pathology report</i> <input type="checkbox"/> VH Mutation Analysis <input type="checkbox"/> Microsatellite Instability by PCR Check if whole blood submitted <input type="checkbox"/>
NOTE: submit a normal block or peripheral blood with tumor sample
Include Pathology report● <input type="checkbox"/> Extract DNA for future testing <input type="checkbox"/> Extract RNA for future testing <input type="checkbox"/> Other _____ <p>◆ 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</p> |
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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 Provide % neoplastic cells in sample submitted <p>RNA Studies –ship on wet ice, DNA Studies ship at room temperature</p>
Bone Marrow	<ul style="list-style-type: none"> 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	<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 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:
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