AVERO DIAGNOSTICS

BREAST PATHOLOGY REQUISTION

BR10000

PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY) | PATIENT MRN

TELEPHONE NUMBER

SEX ☐ Female ☐ Male ☐ Other/Unknown

STREET NUMBER | STREET NAME | APT NUMBER

CITY | STATE | ZIP

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I may be responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim.

PATIENT SIGNATURE X | DATE (MM/DD/YY)

SPECIMEN INFORMATION – REQUIRED

Collected on: | Time: ☐ AM ☐ PM

Time (Bx to Fixative): ☐ AM ☐ PM

DIAGNOSTIC INFORMATION (ICD-10) (Check all that apply)

☐ **MEDICARE SCREENING**
See Medicare Section & Sign Advance Beneficiary Notice of Noncoverage (ABN)

- ☐ N63.0 Unspecified Lump in Breast, Unspecified Breast
- ☐ N63.1 Unspecified Lump in the Right Breast
- ☐ N63.2 Unspecified Lump in the Left Breast
- ☐ D24. Benign Neoplasm of the Right Breast
- ☐ D24.2 Benign Neoplasm of the Left Breast
- ☐ R92.0 Mammographic Microcalcification Found on DiagnosticImaging of Breast
- ☐ Other: _____

SURGICAL PROCEDURE

- ☐ Sono - Guided Vacuum - Assisted Biopsy, _____ g Cores
- ☐ Stereo - Guided Vacuum - Assisted Biopsy, _____ g Cores
- ☐ MRI - Guided Vacuum - Assisted Biopsy, _____ g Cores
- ☐ Core Needle Biopsy
- ☐ Lumpectomy/Excisional Biopsy
- ☐ Fine Needle Aspiration (FNA)/Cyst Aspiration
- ☐ HALO™ Breast Pap Test
- ☐ Other: _____

TEST OPTIONS

* Diagnoses of invasive carcinoma will be tested for ER,PR,Ki-67, p53 & HER-2 by immunohistochemistry (IHC)

* Diagnoses of DCIS will be tested for ER & PR.

* Additional testing at physician request:

- ○ PathVysion (HER-2 FISH) Only
- ○ Other: _____

CLINICIAN INFORMATION

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

REQUIRED ORDERING CLINICIAN SIGNATURE X | DATE (MM/DD/YY)

BILLING INFO

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

INSURANCE COMPANY

IPA NAME

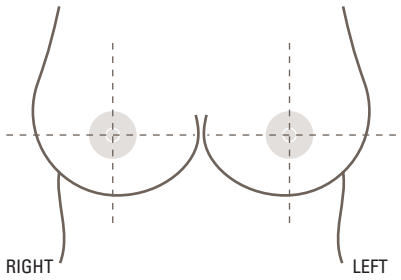
MEMBER ID

☐ **BILL PATIENT** Patient will be contacted to provide payment method.

☐ **CLIENT BILL**

PERTINENT CLINICAL INFORMATION

CLINICAL DIAGRAM
(Mark Location of Biopsy(s))



ACR Category:

SPECIMEN INFORMATION (ANATOMIC ORIGIN OF SPECIMEN)

1. _____ Breast, _____ , _____ CMFN ☐ Sono ☐ Stereo ☐ MRI ☐ FNA

2. _____ Breast, _____ , _____ CMFN ☐ Sono ☐ Stereo ☐ MRI ☐ FNA

3. _____ Breast, _____ , _____ CMFN ☐ Sono ☐ Stereo ☐ MRI ☐ FNA

AV-23001-01 REV 082022

SPECIMEN LABELS:

These labels are for the purpose of identifying the specimens with this requisition. Please affix to the side of each specimen vial you are submitting.

BR10000 1. _____ Breast, _____ , _____ CMFN ☐ Sono ☐ Stereo ☐ MRI ☐ FNA

BR10000 2. _____ Breast, _____ , _____ CMFN ☐ Sono ☐ Stereo ☐ MRI ☐ FNA

BR10000 3. _____ Breast, _____ , _____ CMFN ☐ Sono ☐ Stereo ☐ MRI ☐ FNA

AVERO® DIAGNOSTICS

Bellingham Laboratory
3560 Meridian Street, Suite 101
Bellingham, WA 98225
360.527.4580

Dallas Laboratory
6221 Riverside Drive, Suite 119
Irving, TX 75039
877.232.9924

www.averodx.com

A. Notifier: _____

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

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (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

Form CMS-R-131 (Exp. 06/30/2023) *Form Approved OMB No. 0938-0566*

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