AVERO DIAGNOSTICS

DERMATOLOGY SURGICAL PATHOLOGY REQUISITION

SP088001

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 | DATE (MM/DD/YY)

X

SPECIMEN INFORMATION – REQUIRED

Collected on: | Time: ☐ AM ☐ PM

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 | DATE (MM/DD/YY)

X

BILLING INFO

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

INSURANCE COMPANY

IPA NAME

MEMBER ID

☐ **BILL PATIENT** (Cash pay, no insurance)

☐ **CLIENT BILL**

Patients are advised that they may be responsible for payment if their insurance company applies covered charges to the patient's deductible or to co-pay/co-insurance. Some insurances may not cover the charges for the AMBLor® test. In this case, the patient will be responsible for paying for the test ($460 out of pocket maximum, or $299 if paid up front or within 30 days of billing). Patients may contact Avero Diagnostics' billing department at **844.745.8249 to learn about possible payment plans or need-based fee reductions.*

DIAGNOSTIC INFORMATION (ICD-10)

PHYSICIAN NOTICE: Medicare will only pay for medical necessity testing supported with a symptomatic diagnosis. Medicare patients should sign the Advance Beneficiary Notice of Noncoverage (ABN) on the back of the requisition.

SURGICAL PATHOLOGY

BIOPSY TYPE

☐ Shave ☐ Punch ☐ Excision

Specimen must include uninvolved epidermis adjacent to lesion for evaluation.

☐ Check if Slide Prep ONLY

ADDITIONAL TESTING

Select all tests required: ☐ AMBLor®

The AMBLor® test consists of 3 separate components: AMBRA1, Loricrin and Risk Assessment.

Specimen Source:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

ADDITIONAL CLINICAL INFORMATION/PREVIOUS HISTORY

AMBLor® TESTING FOR MELANOMA* *(AMBLor® testing can only be done on primary specimens.)*

BLOCK NUMBER(S)

MELANOMA AJCC STAGING

☐ Stage I ☐ Stage II *(Please do not send Stage III or IV)*

☐ Non-ulcerated *(Please do not send ulcerated samples)*

Testing not available in New York State. AMBLor® is a registered trademark of AMLo Biosciences.

REQUIREMENTS:

- 5 x FFPE sections, 4 micron thickness, mounted on charged, air-dried, unclipped slides
- Patient histopathology report

Failure to provide correctly prepared sample and the required patient and clinical information may result in a delay to the request

- Include Avero FedEx account number (895157074) and lab address as noted below.

SHIP TO: Avero Diagnostics
Attn: AP Accessioning
3614 Meridian Street, Suite 100
Bellingham, WA 98225

AV-23006-01 REV032023

SP088001 PATIENT NAME _____ DATE OF BIRTH _____

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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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To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov

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