Stanford HEALTH CARE
STANFORD MEDICINE

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

Cytogenetics (Genetics/Prenatal)

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

Submitter ID 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. 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.

PRENATAL ANALYSIS

√	Test Name	Test Code	Clinical Information	
☐	Amniotic Fluid, Chromosome Analysis	CG AMNIO	Gest. Age_____	LMP_____
☐	Chorionic Villi, Chromosome Analysis	CG CVS	Gravida_____	Para_____
☐	Percutaneous Umbilical Blood, Chromosome Analysis	CG BLOOD	SAB_____	TAB_____

GENETIC ANALYSIS

√	Test Name	Test Code	Clinical Information
☐	Blood , chromosome analysis (routine)	CG BLOOD	Clinical indication (must be completed):
☐	Blood, Breakage analysis, Fanconi Anemia	CG FANCONI	
☐	Blood, Breakage analysis, Ataxia Telangiectasia	CG ATAXIA	
☐	Tissue, chromosome analysis, (prod. of concept.)	CG TISS POC	Tissue type:___________________________
☐	Tissue, chromosome analysis, (skin/other tissue)	CG TISS SKIN	
☐	Tissue Culture, Reference Test	CG TISS REF	Reference Lab/Test (referral paperwork must be provided):

FISH ANALYSIS (Fluorescence In Situ Hybridization)

√	Test Name	Test Code	√	Test Name	Test Code
☐	Prenatal FISH Panel (amn. fld.; X, Y, trisomy 13, 18, 21)	CGF PRENAT	☐	Miller-Dieker Syndrome 17p13	CGF MDK
☐	DiGeorge/Velocardiofacial Synd. 22q11.2	CGF VCF	☐	Smith-Magenis Syndrome 17p11.2	CGF SMS
☐	Prader-Willi Syndrome 15q11.2	CGF PWS	☐	Williams Syndrome 7q11.2	CGF WMS
☐	Angelman Syndrome 15q11.2	CGF ANGLM	☐	Other please specify:________________	CGF MCDEL

aCGH (Array Comparative Genomic Hybridization)

√	Test Name	Test Code	Clinical Information
☐	aCGH Genetic diagnosis	CGH GEN	

REQUIRED: Parental control blood specimens in NaHeparin (5mL)

(12/2014)

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.

First sample collected should always be a green top (sodium heparin) tube when Blood, Chromosome Analysis is requested.

CHROMOSOME ANALYSIS & FLUORESCENCE IN SITU HYBRIDIZATION (FISH)	**Lab Phone Number (650) 725-6396**
Chromosome Analysis and FISH testing can be performed from a single patient sample if volume is adequate	
Whole Blood	· Minimum 4 mL · Green-top (sodium heparin) tube · Maintain specimen at room temperature
Fluid	· 20 – 30 mL Amniotic fluid – Sterile container · Provide multiple aliquots (Two 15mL aliquots) · Maintain specimen at room temperature
Tissue	· 0.5-1 cm^3 tissue · Sterile tube containing RPMI cell culture media, Sterile saline acceptable if media unavailable

Ship to:
If shipping Friday check for Saturday delivery
Phone: 1 (877) 717-3733

Stanford Anatomic Pathology and Clinical Laboratory
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.

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.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566