

CLIENT INFORMATION PLEASE CHECK REQUESTING PHYSICIAN

CHECK ONE: TC ONLY GLOBAL CONSULTATION

PATIENT INFORMATION (Green highlighted sections are required information)

Please attach patient face sheet and front and back of primary and secondary insurance card: See Attached

Name (Last, First): _____

Date of Birth: ___/___/___ Sex: M F SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Medical Record #: _____

I hereby authorize the release to EmeritusDX of any medical and insurance information necessary to process claims for services provided by EmeritusDX. I hereby authorize EmeritusDX to pursue all necessary appeals of full or partial denials of payment in relation to services provided by EmeritusDX.

Patient Signature: _____

CLINICAL INFORMATION

COLLECTION DATE: ___/___/___

Clinical History: _____

BILLING INFORMATION

Primary: Medicare Medicaid Insurance Patient Client

Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ DOB: _____

Policy Holder: Self Spouse Child Other

Secondary: Medicare Medicaid Insurance Patient Client

Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

ICD-10 CODES Physician is required to submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity.

- D12.6 Benign neoplasm, colon unsp.
- D12.8 Benign neoplasm, rectum
- D13.1 Benign neoplasm, stomach
- K29.00 Acute gastritis, w/o bleeding
- K29.70 Gastritis unsp., w/o bleeding
- K29.80 Duodenitis, w/o bleeding
- K29.90 Gastroduodenitis unsp., w/o bleeding
- K52.9 Noninfective gastroenteritis & colitis unsp.
- K57.30 Diverticulosis, lg intestine w/o perforation or abscess, w/o bleeding
- K57.31 Diverticulosis, lg intestine w/o perforation or abscess, w/ bleeding
- K57.32 Diverticulitis, lg intestine w/o perforation or abscess, w/o bleeding
- K57.33 Diverticulitis, lg intestine w/o perforation or abscess, w/ bleeding
- R10.84 Generalized abdominal pain
- R12 Heartburn
- K31.7 Polyp, stomach & duodenum

- K62.0 Polyp, anal
- K62.1 Polyp, rectal
- K63.5 Polyp, colon
- K62.5 Hemorrhage, anus & rectum
- K64.8 Other hemorrhoids
- R19.4 Change in bowel habit
- R19.8 Other symptoms, digestive system & abdomen
- Z12.0 Screen for malig. neoplasm, stomach
- Z12.10 Screen for malig. neoplasm, intestinal tract
- Z12.11 Screen for malig. neoplasm, colon
- Z12.12 Screen for malig. neoplasm, rectum
- Z12.13 Screen for malig. neoplasm, sm. intestine
- Other(s): _____
- Colon Cancer Screening Average High Risk

RULE OUT

- Adenoma
- Barrett's Esophagus/Dysplasia
- Candida
- Carcinoma
- Celiac Sprue
- Crohn's
- Eosinophilic Esophagitis
- Fungi
- H. Pylori
- Lymphoma
- Mastocytic Enterocolitis
- Microscopic Colitis
- Ulcerative Colitis
- Virus
- Other: _____

BIOPSY DATA

UPPER GI

SPECIMEN TYPE:						SPECIMEN LOCATION:											ENDOSCOPIC FINDINGS	
Specimen Label	Biopsy	Polyp Biopsy	Polypectomy	Random Biopsy	Cytology/Brushing	ESOPHAGUS		STOMACH					SMALL INTESTINE				Site - Other	
						Esophagus	EG Junction	Stomach	Cardia	Fundus	Body	Antrum	Pylorus	Small Intestine	Duodenum	Duodenum Bulb		
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LOWER GI

SPECIMEN TYPE:						SPECIMEN LOCATION:											ENDOSCOPIC FINDINGS		
Specimen Label	Biopsy	Polyp Biopsy	Polypectomy	Random Biopsy	Cytology/Brushing	ILEUM		COLON					RECTO-SIGMOID				Site - Other		
						Ileum	Ileocecal Valve	Colon	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Recto-Sigmoid			Rectum
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BARRETT'S ESOPHAGUS (BE) FISH TESTING

Specimen Sites: EG Junction All Esophageal BXs Specific Site(s) /specify by specimen label): _____ Site(s) with BE Dx: _____

Tissue (if columnar mucosa present): BE FISH Tissue Comprehensive BE FISH Tissue (BE FISH plus IHC stains: Ki-67, p53)

Cytology: BE FISH Cytology Comprehensive BE FISH Cytology (BE FISH plus special stains: Feulgen & Alcian Blue; plus IHC stains: Ki-67, p53, AMACR) Other: _____

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

Physician/Authorized Signature _____ Date _____/_____/_____

Signature required on this order or in the patient's medical record

Please Discard Extra Labels

1-Complete all required information on requisition. 2-Use appropriate number of labels provided. 3-Place 1 label on each specimen container (not on lid).

Esophagus Location _____ Pt. Name _____ Vial # _____	Stomach Location _____ Pt. Name _____ Vial # _____	Colon Location _____ Pt. Name _____ Vial # _____	Colon Location _____ Pt. Name _____ Vial # _____
Esophagus Location _____ Pt. Name _____ Vial # _____	Stomach Location _____ Pt. Name _____ Vial # _____	Colon Location _____ Pt. Name _____ Vial # _____	Colon Location _____ Pt. Name _____ Vial # _____
Cytology Brushing, Nodule Location _____ Pt. Name _____ Vial # _____	Duodenum Location _____ Pt. Name _____ Vial # _____	Colon Location _____ Pt. Name _____ Vial # _____	Colon Location _____ Pt. Name _____ Vial # _____
Cytology Brushing, Pan Area Location _____ Pt. Name _____ Vial # _____	Small Intestine Location _____ Pt. Name _____ Vial # _____	Other Location _____ Pt. Name _____ Vial # _____	Other Location _____ Pt. Name _____ Vial # _____