South Bend Medical Foundation
530 North Lafayette Boulevard
South Bend, IN 46601-1098

SPECIAL STAINS/ IMMUNOPEROXIDASE REQUISITION

J. L. Simpson, M.D. Medical Director

Client Code: ( ) Name: ______________________

✓ Dr # Physician's Last Name, First Name

[ ] ______________________
[ ] ______________________
[ ] ______________________
[ ] ______________________
[ ] ______________________
[ ] ______________________
[ ] ______________________

Signature of Ordering Provider

____

(Signature must be dated, legible, and include first and last name)

Date______________________

PATIENT INFORMATION – Please PRINT

Name ______________________
Last First MI

SS#______________________

DOB______________________ SEX ______
MO / DAY / YEAR

SPECIMEN COLLECTION

Date ____________ Collector's Initials ________
MO / DAY / YEAR

Time: ________ ☐ AM ☐ PM Tissue Type _____

If ER PR or HER2 ordered:

Was the specimen placed in formalin within one hour of collection? ☐ Yes ☐ No

Was the formalin fixation time between 6 and 72 hours? ☐ Yes ☐ No

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE (SEE REVERSE)

IF NO BILLING INFORMATION IS PROVIDED, AND NO BOX IS CHECKED YOUR ACCOUNT WILL BE BILLED.

Immunoperoxidase Stains
CHARGE# 26105

CPT Code X 1
CPT 88342 (unless otherwise indicated)

PANELS

- ☐ **BREAST (MON, WED, FRI) (*PAN-BRST)X 2**
  ER, PR, HER-2/Neu by FISH (CPT 88374)
- ☐ **CLL PANEL X 3**
  CD-5, CD-10, CD-23
- ☐ **CYTO 7 & 20 (*PAN-CYTO7/20) X 2**
  CYTOKERATIN 7, CYTOKERATIN 20
- ☐ **ER/PR (MON, WED, FRI) (*PAN-ER/PR) X 2**
  ER, PR
- ☐ **HODGKINS (*PAN-HODGKINS) X 9**
  CD3, CD15, CD20, CD30, CD45, EBV-LMP, EMA, FASCIN, PAX5
- ☐ **IMMUNOGLOBULIN (*PAN- IMMUNOGL)**
  IgA, IgG, IgM, KAPPA, LAMBDA **X 5**
- ☐ **KAPPA, LAMBDA (*PAN-KAPLAM) X 2**
  KAPPA, LAMBDA
- ☐ **LCL (*PAN-LCL) X 12**
  ALK-1, BCL-2, BCL-6, CD3, CD5, CD10, CD20 CD23, CD79A, KI-67 (MIB), MUM-1, PAX-5
- ☐ **LUNG CA (*PAN-LUNG CA) X 2**
  P40, TTF
- ☐ **MELANOMA (*PAN-MELANOMA) X 3**
  HMB45, MELAN-A, SOX-10
- ☐ **MMR (*PAN-MMR) X 4**
  MLH-1, MSH-2, MSH-6, PMS-2
- ☐ **MYOEPITHEIAL (*PAN-MYOEPI) X 2**
  P63, SMMHC
- ☐ **PROSTATE (*PAN-PROSTATE) X 2**
  PSA, PSMA
- ☐ **SENTINAL NODE (PAN-AE/CAM) X 2**
  AE 1/3, CAM 5.2
- ☐ **SLL (*PAN-SLL) X 11**
  CD3, CD5, CD10, CD19, CD20, CD23, CD43, BCL2, BCL6, CYCLIN-D, KI-67 (MIB)

INDIVIDUAL IMMUNOPEROXIDASE STAINS

☐ 34BE12
☐ AE 1/3
☐ AFP
☐ ALK-1
☐ BCL-2
☐ BCL-6
☐ BETA-CATENIN
☐ BOB.1
☐ CALCITONIN
☐ CALRETININ
☐ CAM 5.2
☐ CD-1a
☐ CD-2
☐ CD-3
☐ CD-4
☐ CD-5
☐ CD-7
☐ CD-8
☐ CD-10
☐ CD-15
☐ CD-19
☐ CD-20
☐ CD-21
☐ CD-23
☐ CD-30
☐ CD-31
☐ CD-34
☐ CD-43
☐ CD-45
☐ CD-56
☐ CD-57
☐ CD-61
☐ CD-68
☐ CD-71
☐ CD-79a
☐ CD-99
☐ CD-117
☐ CD-138
☐ CDX-2
☐ CEA- MONO
☐ CHROMAGRANIN
☐ CMV
☐ CYCLIN D
☐ CYTO 5/6
☐ CYTO 7
☐ CYTO 20
☐ DESMIN
☐ EBV-LMP
☐ E-CADHERIN
☐ EMA
☐ ER
☐ FACTOR VIII
☐ FASCIN
☐ GCDFP
☐ GFAP
☐ GLYPICAN-3
☐ GRANZYME
☐ HCG
☐ H. PYLORI
☐ HEPATOCYTE
☐ HMB-45
☐ INHIBIN
☐ IgA
☐ IgG
☐ IgM
☐ KAPPA
☐ KI-67 (MIB)
☐ LAMBDA
☐ LYSOZOME
☐ MAMMAGLOBIN
☐ MELAN-A
☐ MLH-1
☐ MSH-2
☐ MSH-6
☐ MUM-1
☐ MYELOPEROXIDASE
☐ NAPSIN
☐ NSE
☐ OCT.2
☐ PAX-5
☐ PAX-8
☐ P16
☐ P40
☐ P53
☐ P57
☐ P63
☐ PLAP
☐ PMS2
☐ PR
☐ PSA
☐ PSAP
☐ PSMA
☐ RENAL CELL
☐ S-100
☐ SARC. ACTIN
☐ SMA
☐ SMMHC
☐ SOX-10
☐ SYNAPTOPHYSIN
☐ TDT
☐ THROMBOMODULIN
☐ THYROGLOBULIN
☐ TTF
☐ UROPLAKIN III
☐ VIMENTIN
☐ WT-1

Special Stains Group I (Microorganisms)
CHARGE# 26017 CPT 88312

☐ ACID FAST
☐ GRAM STAIN
☐ FITE
☐ PAS-FUNGI
☐ STEINER
☐ PNEUMOCYSTIS
☐ SILVER CHROMATE
☐ WARTHIN-STARRY

TYPE OF FIXATIVE:

Special Stains Group II (Other)
CHARGE# 26117 CPT 88313

☐ ALICIAN BLUE
☐ ALICIAN BLUE/PAS
☐ BILE
☐ BIELSCHOWSKI
☐ CALCIUM
☐ CHLORACETATE ESTERASE
☐ COLLOIDAL IRON
☐ CONGO RED
☐ COPPER
☐ CRYSTAL VIOLET
☐ ELASTIC
☐ GIEMSA (MAST CELLS)
☐ H&E
☐ HEMOSIDERIN (IRON)
☐ LUXOL FAST
☐ MELANIN BLEACH
☐ MELANIN
☐ MUCICARMINE
☐ OIL RED O
☐ PAS
☐ PAS DIASTASE
☐ PASM
☐ RETICULIN
☐ SIDEROCYTE
☐ TRICHROME

South Bend Medical Foundation
Your Community Laboratory

For our locations and hours please visit our website @ www.sbmf.org or call us at
574-234-4176 and press 5
800-544-0925 and press 5

INSURANCE INFORMATION

Responsible Party Name (required if patient is a minor):

Responsible Party Address:

City | State | Zip

Responsible Party Phone
( ) ______ - ____________

☐ Medicare # ________________________

☐ Medicaid # ________________________ EDD ____________
M/D/Y ____________

☐ Primary Insurance (Complete or attach copy of insurance card.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self	☐ Spouse	☐ Parent
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

☐ Secondary Insurance (Complete or attach copy of insurance card front & back.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self	☐ Spouse	☐ Parent
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

IMPORTANT
A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, ONLY TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED.

MICROBIOLOGY PROTOCOL
MICROBIOLOGY CULTURES MAY INCLUDE CHARGES FOR ONE PRIMARY SOURCE SMEAR, ONE PRIMARY CULTURE, ONE CHARGE PER ORGANISM REQUIRING IDENTIFICATION, AND ONE CHARGE PER SENSITIVITY PERFORMED. This is source specific. Refer to the fee schedule for further clarification, or call The Medical Foundation Client Services Department at (574) 236–7263 or (800) 950-7263

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

EVERY patient MUST read, sign, and date:

I request that payment of authorized Medicare or insurance benefits be made on my behalf to the South Bend Medical Foundation.

I authorize any holder of medical or other information about me to release to my designated insurance company, Centers for Medicare and Medicaid Services (CMS), and their agents, information to determine payable benefits for related services.

I agree that I am fully responsible for the payment of all the designated laboratory services South Bend Medical Foundation rendered to me or on my behalf. I accept responsibility for charges Medicaid does not cover when I am enrolled in a limited coverage Medicaid program.

I understand that additional testing may be performed based on my physician's request. I agree to be fully responsible for payment if my insurance plan does not cover the cost.

I also agree that if any insurance plan, except Medicaid, determines the tests requested to be medically unnecessary, and/or uncovered procedures, and denies payment to the South Bend Medical Foundation, I accept full responsibility for payment to South Bend Medical Foundation.

Patient Signature | Date