Breast Pathology Approved Protocol Selection

Practice Name	Account Number

At my request, I hereby authorize Inform Diagnostics to perform the Approved Protocol, as individually selected below, that I believe to be medically appropriate for the diagnosis and/or treatment of my patients, on specimens that I send to Inform Diagnostics for diagnostic testing.

It is Inform Diagnostics' responsibility to emphasize clinician choice, proper disclosure, client/clinician education, and to facilitate the ability of a client/clinician to order any testing that he/she believes to be medically appropriate* for the diagnosis and/or treatment of his/her patients.

TEST REFLEX TO	REFLEX CRITERIA & MEDICAL RATIONALE (check all that apply)
fulgent Oncology Hereditary Cancer Panel	☐ **Breast Cancer Focus Panel** **Recommended Criteria** **Breast:** Patients age 50 and under. Patients over 50 with any of the following: triple negative features, multiple primary tumors, male breast cancer, Ashkenazi Jewish ancestry, certain family histories, or to aid in making specific treatment decisions. *By checking the box, you authorize the initiation of the ordering of a cancer-specific comprehensive panel.*

By signing below, I am aware of the test components, the CPT† codes for the components, and the reimbursement rates for the tests ordered. I am also aware that the use of a protocol order may result in the ordering of tests which are not covered, reasonable or necessary. I understand the potential implications of signing a protocol order. I also understand that I have the ability to "Opt Out" of the protocol order for each patient by writing "Opt Out" on the individual test requisition, or for all my patients by contacting Inform Diagnostics' Client Services at 866.588.3280.

I confirm that informed consent will be obtained, if required by state law. I certify that I will discuss with each patient their results and how their results inform treatment recommendations. I attest that the clinician name listed below is authorized by law in the relevant jurisdiction to order the test(s) requested herein. I confirm that I maintain on file each patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers.

Clinician Name _____ Signature _____ Date _____

Clinician Name _____ Signature _____ Date _____

Clinician Name _____ Signature _____ Date _____

Clinician Name _____ Signature _____ Date _____

Clinician Name _____ Signature _____ Date _____

Please return the signed form to Inform Diagnostics

Fax 866.688.3280
OR **Email** clientservices@informdx.com

***MEDICAL NECESSITY**
The Centers for Medicare and Medicaid Services (CMS) is responsible for administering Medicare and other federally mandated healthcare programs throughout the United States. Medicare laws prohibit payment for services and items deemed by local Medicare Carriers as not medically reasonable and necessary for the diagnosis or treatment of an illness or injury. In such cases, documentation of "medical necessity" is required before a claim may be paid. Medicare, with a few exceptions, will not pay for routine checkups or screening tests, defined as "diagnostic procedures performed in the absence of signs or symptoms."

†CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payor being billed.

Document ID: _____ **Your selections will be implemented upon receipt in our lab.**