Gastroenterology (GI) Pathology
Approved Protocol Selections

Practice Name ________________________________________________  Account Number ________________________

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

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 necessary and appropriate** for the diagnosis and/or treatment of his/her patients.

<table>
<thead>
<tr>
<th>STAIN</th>
<th>SPECIMEN(S) TYPE AND MEDICAL RATIONALE — MEDICAL NECESSITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcian Blue/PAS</td>
<td>- Gastric specimens: To enhance the detection of intestinal metaplasia¹</td>
</tr>
<tr>
<td>CPT Code: 88313*</td>
<td>- Duodenal specimens: To enhance the detection of gastric metaplasia in inflammatory conditions such as peptic duodenitis¹</td>
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<td></td>
<td>- Esophageal specimens: To enhance the detection of intestinal metaplasia in Barrett’s esophagus¹²</td>
</tr>
<tr>
<td>IHC for H. pylori</td>
<td>- Gastric specimens: To enhance the detection of Helicobacter pylori³</td>
</tr>
<tr>
<td>CPT Code: 88342*</td>
<td></td>
</tr>
</tbody>
</table>

Your protocol selections will be implemented within 24–48 hours from receipt at Inform Diagnostics.

Please note that this Approved Protocol Form supersedes and replaces any existing Approved Protocol Form that you may have on file with Inform Diagnostics.

By signing this form, I indicate that I am aware of the test components, the CPT* codes for the components, and the Medicare reimbursement rates for the tests ordered. I am also aware that the use of a blank order may result in the ordering of tests which are not covered, reasonable or necessary. I understand the potential implications of signing a blanket order. I also understand that I have the ability to “Opt Out” of the blanket order protocol for each patient by checking the “Opt Out” box or by writing “Opt Out” on the individual test requisition form for each patient, or for all my patients, by contacting Inform Diagnostics’ Client Services team at 866.588.3280.

Pathologist Name ________________________________________________________

Signature ____________________________________________________________________  Date _______ /_______ /_____

Pathologist Name ________________________________________________________

Signature ____________________________________________________________________  Date _______ /_______ /_____

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Additional Pathologists

Pathologist Name ________________________________________________________

Signature ____________________________________________________________________  Date _______ /_______ /_____

Pathologist Name ________________________________________________________

Signature ____________________________________________________________________  Date _______ /_______ /_____

Pathologist Name ________________________________________________________

Signature ____________________________________________________________________  Date _______ /_______ /_____

This protocol will be effective on the date that the Medical Director at Inform Diagnostics reviews and approves.

Please return the signed form to Inform Diagnostics

Irving, Texas    Union, N.J.    Boston
Fax    866.688.3280    Fax    908.912.8750    Fax    617.969.3393
Email   clientservices@informdx.com    Email   clientservices2@informdx.com    Email   clientservicesboston@informdx.com

This protocol form has been reviewed and approved by the Medical Director of Inform Diagnostics.

Signature ____________________________________________________________________  Date _______ /_______ /_____

REFERENCES

*The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

**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.”