Center for Molecular Cancer Diagnostics, INC.

FISH for Bladder Cancer *(Ordering Code: BlaFISH)*

Support Documents:	Fluorescence in situ Hybridization (FISH) for Recurrent Bladder Cancer: Detection of Genetic Alterations in Bladder Cancer Cells
Methodology Name And Description:	Fluorescent In-Situ Hybridization (FISH)
Specimen Requirements:	Testing Volume/Size: 50 mL; Type: Urine, Thin Prep fixed; Container: Clean container with Thin Prep medium; Notes: Add 30mL of preserveCYT to 70mL urine specimen.
Minimum Specimen Requirement	Volume/Size: 50 mL;
Stability:	Refrigerated: 72 hours
Special Info:	Submit requisition for requested FISH test.
Clinical Info:	Follow-up to detect recurrence and tumor progression in patients with bladder cancer.
Days Performed:	Monday – Friday (CMCD Holidays Excluded)
Reported:	3 Days from receipt of acceptable specimen in lab
CPT Code(s):	88120(x1)

CLIA# 36D2061372
CAP# 7541618
ADDRESS: 8285 Darrow Road, Ste 101 Twinsburg, OH 44087
PHONE: 330-405-2623

Center for Molecular Cancer Diagnostics, INC.

LAB USE ONLY	
Received by	
Date Rec'd	Time Rec'd

ACCOUNT INFORMATION

Account No. **Phone No.**

Treating Physician **UPIN No.**

Requesting Physician Signature
I certify that I intend to order the services indicated which I consider medically necessary for the diagnosis and treatment of the patient. In accordance with CMS guidelines, all laboratory orders must either be signed by the ordering physician on the requisition or be documented and signed in the patient's medical record.

Duplicate Report To:

Address:

Fax:

PATIENT INFORMATION

Last Name **MI**

First Name

Street

City **State** **Zip**

Phone No.

Sex: ☐ (M) ☐ (F) **DOB**

Patient ID No. **Chart No.**

BILLING INFORMATION

Bill to: Select One

☐ Medicare ☐ Medicaid ☐ Patient's Insurance ☐ Physician Bill ☐ Self Pay ☐ Other Insurance

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

Patient is: ☐ Subscriber ☐ Spouse ☐ Other Dependent

Primary Insurance Name: **Policy No.**

Group No. **Insured's Name:**

Address: **City:** **State:** **Zip:**

Secondary Insurance Name: **Policy No.**

Group No. **Insured's Name:**

Address: **City:** **State:** **Zip:**

SOLID TUMOR

ICD-9 Code **Collection Date** **Specimen Submitted** ☐ DNA ☐ FFPE

Specimen Type

☐ Colorectal Cancer ☐ GI Cancer ☐ Glioma ☐ Lung Cancer ☐ Bladder Cancer ☐ Other

Test Requested

☐ Bladder Cancer FISH ☐ Her2-neu FISH

Additional Notes

PATIENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Patient Signature **Date**