MYRIAD myPath® Melanoma

DATE OF BIOPSY (REQUIRED)

(MM/DD/YYYY)

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM AND INCLUDE A PATHOLOGY REPORT

At the time of specimen collection: ☐ Non-Hospital Patient ☐ Hospital Outpatient ☐ Hospital Inpatient (>24 hour stay) Discharge date: ______ (MM/DD/YYYY)

1. Patient Information (Complete information required)

Name (last)	Name (first)	(m.i.)	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Patient ID #

Email	Cell phone	Daytime phone

Address	City	State	Zip

2. Ordering Provider Information (Dermatopathologist) (Only name and HCP Account # required unless you're a new customer or HCP # is unknown)

Name (last)	Name (first)	Degree	Myriad HCP Account #	NPI #

Address	City	State	Zip

Office Contact Name	Phone	Fax	Email

3. Referring Provider Information (Dermatologist)

Name (last)	Name (first)	Degree	Myriad HCP Account #	NPI #

Address	City	State	Zip

Office Contact Name	Phone	Fax	Email

4. Specimen Information Required

SAMPLE FIXATIVE: ☐ 10% Neutral buffered formalin
☐ Other (description): ______

SPECIMEN IDENTIFICATION NUMBER(S): ______

PROCEDURE TYPE: ☐ Punch Biopsy ☐ Shave Biopsy ☐ Excisional Biopsy

TISSUE TYPE (e.g., skin): ______

ANATOMICAL SITE (e.g., left ear): ______

DIFFERENTIAL DIAGNOSIS:

1. ______
2. ______
3. ______

MEDICARE COVERED ICD-10 CODES:

- ☐ **D49.2** Neoplasm of unspecified behavior of bone, soft tissue, and skin
- ☐ **D48.5** Neoplasm of uncertain behavior of skin
- ☐ **D22.9** Melanocytic nevi, unspecified
- ☐ **D22.72** Melanocytic nevi of left lower limb, including hip
- ☐ **D22.71** Melanocytic nevi of right lower limb, including hip
- ☐ **D22.70** Melanocytic nevi of unspecified lower limb, including hip
- ☐ **D22.62** Melanocytic nevi of left upper limb, including shoulder
- ☐ **D22.61** Melanocytic nevi of right upper limb, including shoulder
- ☐ **D22.60** Melanocytic nevi of unspecified upper limb, including shoulder
- ☐ **D22.5** Melanocytic nevi of trunk
- ☐ **D22.4** Melanocytic nevi of scalp and neck
- ☐ **D22.39** Melanocytic nevi of other parts of face
- ☐ **D22.30** Melanocytic nevi of unspecified part of face
- ☐ **D22.22** Melanocytic nevi of left ear and external auricular canal
- ☐ **D22.21** Melanocytic nevi of right ear and external auricular canal
- ☐ **D22.20** Melanocytic nevi of unspecified ear and external auricular canal
- ☐ **D22.10** Melanocytic nevi of unspecified eyelid, including canthus
- ☐ **D22.0** Melanocytic nevi of lip

NON-MEDICARE COVERED ICD-10 CODE(S):

☐ Other: ______

5. Sample Validity

Myriad myPath® Melanoma has not been validated on metastatic melanomas, re-excision specimens, non-melanocytic neoplasms, or biopsies from a patient receiving immunosuppressant therapy or radiation therapy. Analysis of these samples may result in incorrect test interpretation; therefore these specimens are not suitable for testing and will be cancelled.

6. Ordering Provider Signature

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I hereby attest that the person listed in the Ordering Provider space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein. To the best of my knowledge, this is an equivocal primary melanocytic lesion, NOT a metastatic melanoma, a re-excision specimen, non-melanocytic neoplasm, or a biopsy from a patient receiving immunosuppressant therapy or radiation treatment. I CERTIFY THAT THE INCLUDED LESIONS ARE SUITABLE FOR TESTING.

SIGN HERE: Medical Professional (required to process form) X ______ Date: ______ (MM/DD/YYYY)

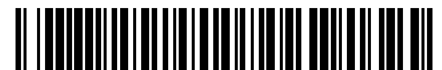
(Signature date is the specimen collection date if a different date is not provided above)

7. Billing/Payment Information

☐ **BILL INSURANCE**

☐ Include enlarged copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

MYRIAD GENETIC LABORATORIES, INC. A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, UT 84108 / **(800) 231-4442 • Fax (801) 582-4000** • myPathMelanoma.com



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Testing for Myriad myPath® Melanoma

IMPORTANT INFORMATION FOR PATIENT*

BILLING TERMS: I represent that I am covered by insurance and authorize Myriad Genetic Laboratories, Inc. (MGL) to give my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the relevant health information necessary for reimbursement. I authorize Plan benefits to be payable to MGL. I understand MGL will contact me if I will be financially responsible for any non-covered service. By agreeing to testing I also authorize Myriad to obtain a consumer credit report on me from a consumer reporting agency selected by Myriad. I understand and agree that Myriad may use my consumer credit report to confirm whether my income qualifies me for financial assistance. I further understand that this is not a credit application and will not impact my credit score. I agree to assist MGL in resolving insurance claim issues and if I don't assist, I may be responsible for the full test cost. I permit a copy of this authorization to be used in place of the original.

NON-DISCRIMINATION: Federal law (GINA) and laws in most states prohibit discrimination regarding employment eligibility, health benefits, or health insurance premiums based solely on genetic information. Myriad Genetic Laboratories, Inc. (Myriad) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

AFFORDABILITY: Myriad Promise™

- If you encounter ANY financial hardship associated with your bill, Myriad will work with you toward your complete satisfaction
- For more information please refer to the billing information at MyriadPromise.com

*Translation of Billing Terms are available in Mandarin and Spanish at MyriadPromise.com. Myriad also provides free language services to people whose primary language is not English through qualified interpreters. If you need these services, contact Customer Service at 800-469-7423.

Medicare Beneficiaries Eligibility — Indications for Use Under myPath LCD ID L37881

THE MYPATH® MELANOMA ASSAY IS COVERED BY MEDICARE WHEN THE FOLLOWING CLINICAL CONDITIONS ARE MET:

- The test is ordered by a board-certified dermatopathologist **and**;
- The specimen is a primary cutaneous melanocytic neoplasm for which the diagnosis is equivocal/uncertain (i.e., clear distinction between benign or malignant cannot be achieved using clinical and/or histopathological features alone) **and**;
- The patient may be subjected to additional intervention, such as re-excision and/or sentinel lymph node biopsy, as a result of the diagnostic uncertainty.