

# Federal Procurement Requisition

# CyPath<sup>®</sup>Lung



**PPLS Use Only:**

Tech Initial: \_\_\_\_\_  
 Result ID: \_\_\_\_\_  
 Date/Time: \_\_\_\_\_

**PPLS  
 Accessioning  
 Department  
 Only**

PATIENT INFORMATION					
Last Name		First Name		M.I.	
Street Address				Apt. #	
City			State	Zip	
Patient Phone			Patient SSN		
Date of Birth	Age	Sex	Client ID #		
BILLING					
Federal Supply Schedule Contract # 36F7972900005 SIN 621 - INP			PO #: _____		
ICD-10 CODE (REQUIRED)					
<input type="checkbox"/> R91.1 Solitary Pulmonary Nodule <input type="checkbox"/> R91.8 Other non-specific abnormal finding of lung field <input type="checkbox"/> Other ICD-10 Codes _____					
CyPath Lung TESTING					
<input type="checkbox"/> CyPath <sup>®</sup> Lung with Acapella <sup>®</sup> Airway Assist Device CPT Code 0406U, E0484 <input type="checkbox"/> CyPath Lung only CPT Code 0406U (Retest) <input type="checkbox"/> Acapella Airway Assist Device only CPT Code E0484					
CyPath Lung Collection Kit					
<input type="checkbox"/> Kit provided to patient IN OFFICE <input type="checkbox"/> Kit to be SHIPPED to patient <input type="checkbox"/> Confirm patient address listed above. If different, enter below					
Shipping Address				Apt. #	
City			State	Zip	
Physician's Office Instruction					
<input type="checkbox"/> Write patient name and date of birth on specimen cup if providing patient kit direct <input type="checkbox"/> Provide patient with collection card and patient coach information. <b>Patient Coach will reach out to patient to train and schedule 3-day collection plan listed below.</b> <b>3 Day Collection Plans:</b> <ul style="list-style-type: none"> <li>• Sunday, Monday, Tuesday</li> <li>• Monday, Tuesday, Wednesday</li> <li>• Tuesday, Wednesday, Thursday</li> <li>• Saturday, Sunday, Monday</li> </ul> <b>Ship MORNING of last day of collection</b>					

CLIENT INFORMATION	
Facility:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Fax:	_____
Email:	_____
Physician NPI #	_____
Test Result Delivered by Fax Test Result Delivered by Email Test Result Delivered by LigoLab Connect Client Portal *	
Select All That Apply:	
* If Requesting Access to Client Portal, See Online Client Portal Agreement	
The undersigned Physician hereby authorizes Precision Pathology Laboratory Services (PPLS) and/or it's affiliated laboratories to send Protected Healthcare Information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160-64) to the following facsimile phone number(s) to the extent such transmission is deemed by Institute for PPLS to be reasonably necessary as part of the professional business relationship between PPLS and Physician.	
Treating Physician _____	
Physician's Signature <b>X</b> _____	
Send Duplicate of Report to:	
Name	_____
Address/Fax	_____
CLINICAL HISTORY (REQUIRED)	
Smoking History:	
Smoking Years: _____	Pack Years: _____
Quit Smoking (>15 years): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Low-dose CT or Imaging available	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please attach copy.	
NOTES:	
<input type="checkbox"/> No Acapella <sup>®</sup> Airway Assist Device Provided _____ _____	

**Precision Pathology Laboratory Services**

**3300 Nacogdoches Road #110 | San Antonio, TX 78217**

Our hours of operation are **Monday–Friday 8:00am to 6:00pm (CST)**. To reach our laboratory, please call **210-646-0890**.

**Please email completed requisition to [reference@precisionpath.us](mailto:reference@precisionpath.us) or fax to 210-962-3497. Please write patient name and date of birth on specimen cup.**

