

# Federal Procurement Requisition

# CyPath® Lung



<b>PPLS Use Only:</b>	Tech Initial: _____	<b>PPLS Accessioning Department Only</b>
	Result ID: _____	
	Date/Time: _____	

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 #		

CLIENT INFORMATION	
Facility:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Fax:	_____
Email:	_____
Physician NPI #	_____

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® Lung with Acapella® 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. Patient Coach will reach out to patient to train and schedule 3-day collection plan listed below.	
<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>	

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 Request Form

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 <input checked="" type="checkbox"/>
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® 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.



## LigoLab Connect Service Privacy Agreement and Sign-Up Form

### **PLEASE COMPLETE ONLY ONE FORM PER USER**

#### **YOUR ORGANIZATION AGREES TO:**

- ✓ Initiate a grant-access request only for individuals who have an express need to view online reports.
- ✓ Immediately initiate a revoke-access request for individuals who no longer have an express need for access to online reports.
- ✓ Electronically assign reports only to the individual(s) who has an express need to view them, in accordance with HIPAA's "minimum necessary" use standard.
- ✓ Implement policies that address the following security practices; at minimum:
  - Keep all login information private.
  - Never leave a computer/mobile device unattended while logged in to the service.
  - Log out as soon as you have finished reviewing results.
  - Use the service in a location where onlookers cannot view the computer/mobile device screen.
- ✓ Take responsibility for any breaches of privacy that occur via any user ID's and passwords that have been granted at your organization's request, regardless of whether or not they are related to HIPAA compliance.
- ✓ Hold the Laboratory harmless for any breaches of privacy which occur as a result of inappropriate use of protected health information via any user ID's and passwords that have been granted at your organization's request, regardless of whether or not they are related to HIPAA compliance.
- ✓ Utilize this service in compliance with all applicable HIPAA regulations.

#### **ACKNOWLEDGEMENT OF RESPONSIBILITY**

**Practice Name:**

**Representative Signature:**

**Representative Printed Name:**

**Date of Sign:**

**USER'S NAME (FIRST AND LAST):** PLEASE PRINT

**USER'S TITLE:** PLEASE PRINT

**USER'S EMAIL ADDRESS:** PLEASE PRINT

**PHYSICIAN NAME(S):**

**PPS Office Use Only:**

*Date User Activation and  
Initials:*

*Date User Deactivation  
and Initials:*

*Database  
Updated:*