PATHOLOGY REFERENCE LABORATORY, L.L.C.

GYN PATHOLOGY REQUISITION

9600 DATAPOINT DR. • SAN ANTONIO, TX 78229
TELE (210) 892-3700 • TOLL FREE (866) 231-8058 • FAX (210) 617-4692

COLLECTION DATE: ____/____/____

BILL TO:
☐ PATIENT or INSURANCE
☐ ACCOUNT or PHYSICIAN
☐ OTHER

ACCOUNT NAME AND ADDRESS

PATIENT LAST NAME | FIRST | M.I.

RELATIONSHIP TO INSURED: ❍ SELF ❍ SPOUSE ❍ DEPENDENT

PHONE ( ) | PATIENT SS # | PATIENT ID/MR # | DATE OF BIRTH / / | SEX ❍ F ❍ M

INSURED NAME/RESPONSIBLE PARTY | INSURED SS #

PATIENT ADDRESS (OR INSURED/RESPONSIBLE PARTY) | APT. NO.

CITY | STATE | ZIP

EMPLOYEE NAME | PHONE ( )

INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS

CITY | STATE | ZIP

INSURANCE COMPANY PHONE ( ) | INSURANCE/GROUP # | MEMBER/SUBSCRIBER ID #

MEDICARE # | SUFFIX ❍ PRIMARY ❍ SECONDARY | MEDICAID # | STATE

SURGICAL PATHOLOGY

SEND DUPLICATE REPORT TO:

CLINICAL HISTORY/COMMENTS:

TISSUE SUBMITTED	ICD CODE
1.	1.
2.	2.
3.	3.
4.	4.

CYTOPATHOLOGY

PLEASE HAVE MEDICARE PATIENTS REVIEW AND SIGN THE SEPARATE ADVANCED BENEFICIARY (ABN) FORM FOR NON-COVERED SERVICE

Please check one box in this section: **ICD code Required:** _____ _____ _____ _____

☐ SCREENING PAP: Routine
☐ SCREENING PAP: High-risk of cervical cancer, screening recommended by physician more often than based on history
☐ DIAGNOSTIC PAP: History, signs or symptoms of abnormality **ICD code** _____

SPECIMEN TYPE: ☐ **SurePath** ☐ **ThinPrep** ☐ **(1-2 slides) Pap Smear** **SPECIMEN SOURCE:** ☐ **Cervix** ☐ **Vagina**

☐ Pap Test Image Guided
☐ Pap Test
☐ HR HPV Regardless
☐ HR HPV Reflex/ASCUS
☐ HPV Reflex Genotype (16,18,45) if HPV Pos/Pap Neg
☐ Cervical DNA FISH if ASCUS/HPV Pos or LSIL
☐ Chlamydia & Gonorrhea
☐ Herpes Simplex I & II
☐ Trichomonas

Panel Specimen Type: ☐ **SurePath** ☐ **ThinPrep** ☐ **Aptima Swab** ☐ **Urine (STI Panel Only)**

☐ **Vaginitis Panel** (Candida albicans, glabrata, tropicalis, parapsilosis, Gardnerella, Trichomonas)
☐ **Leukorrhea Panel** (Candida albicans, glabrata, tropicalis, parapsilosis, Gardnerella, Trichomonas, Chlamydia, Gonorrhea)
☐ **Infertility Panel** (Chlamydia, Gonorrhea, Gardnerella, Trichomonas)
☐ **STI Panel** (Chlamydia, Gonorrhea, Trichomonas)

☐ PRL ProTECT (E6/E7 by Flow) **(Can only be performed on SurePath or ThinPrep)**
*Reflex if Neg or ASCUS Pap/HPV+ (over 30)
*Reflex if ASCUS Pap/HPV + (under 30)
*Reflex if LSIL or ASCUS-H Pap

☐ HPV ONLY (No Pap Test)
☐ HPV HR Reflex ASCUS/LSIL
☐ HPV Reflex Genotype (16,18,45) if HPV Pos/Regardless of Pap
☐ Cervical DNA FISH Regardless of Pap

☐ Chlamydia & Gonorrhea ☐ Chlamydia Only ☐ Gonorrhea Only Source: ☐ Swab ☐ Urine
☐ Trichomonas Only Source: ☐ Swab ☐ Urine
☐ Herpes Simplex I & II Source: ☐ Swab
☐ Group B Strep (Swab) Source: ☐ Vaginal ☐ Rectal ☐ Sensitivities if Pos
☐ BD AFFIRM Source: ☐ Swab

CLINICAL HISTORY:

LAST MENST. PERIOD: _____ DATE OF LAST PAP: _____

PREVIOUS RESULTS: ☐ NORMAL ☐ REACTIVE ☐ AGUS ☐ ASCUS ☐ LGSIL ☐ HSIL

☐ POST PARTUM ☐ TOTAL HYSTERECTOMY ☐ SUPRACERVICAL HYSTERECTOMY ☐ CONTRACEPTIVE: (SPECIFY)
☐ IUD ☐ POSTMENOPAUSAL ☐ PREV RADIATION OR CHEMO _____
☐ DES EXPOSURE ☐ PREGNANT ____WKS ☐ HORMONE THERAPY: (SPECIFY) _____

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Notifier(s):
Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the _____ below.

Test Name	Reason Medicare May Not Pay:	Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the _____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

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