

502-589-1980 866-589-1980 (toll free) 502-589-1982 fax

PHYSICIAN NAME
OFFICE LOCATION

ANATOMIC PATHOLOGY REQUISITION

DATE OF PROCEDURE: ____/____/____

ICD-9-CM _____		Billing Instructions: <input type="checkbox"/> Bill Doctor <input type="checkbox"/> Bill Patient <input type="checkbox"/> Bill Insurance	
Patient & Insurance Information PLEASE COMPLETE INSURANCE INFORMATION OR ATTACH COPY OF INSURANCE CARD(S)			
PATIENT NAME LAST FIRST MIDDLE		DATE OF BIRTH	SOCIAL SECURITY NO.
ADDRESS STREET APT		CITY	STATE ZIP CODE
SEX	MARITAL STATUS	PHONE NO.	RESPONSIBLE PARTY - NAME AND D.O.B.
RESPONSIBLE PARTY ADDRESS STREET		CITY	STATE ZIP CODE
INSURANCE COMPANY		ID NUMBER	GROUP NUMBER ADDRESS

Clinical Information	CLINICAL DATA
PRE OP DIAGNOSIS	POST OP DIAGNOSIS

Specimen Submitted	NON-GYN CYTOLOGY
1. _____	<input type="checkbox"/> FNA: _____
2. _____	<input type="checkbox"/> Bronchial Washing
3. _____	<input type="checkbox"/> Bronchial Brushing
4. _____	<input type="checkbox"/> Body Fluid _____
	<input type="checkbox"/> CSF
	<input type="checkbox"/> Other: _____

PAP Smear Request Form	*Medicare Patients Must Sign Advance Beneficiary Notice On The Last Page For Services*		
1 Slide ____ 2 Slide ____ Thin Layer ____	Screening PAP (Routine) ____	Screening PAP (High Risk) ____	Diagnostic PAP ____
SOURCE	HISTORY	CANCER STATUS	DATE AND RESULTS OF LAST PAP SMEAR
<input type="checkbox"/> Cervical	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Not Suspected	_____
<input type="checkbox"/> Endocervical	<input type="checkbox"/> Post Partum	<input type="checkbox"/> High Risk	_____
<input type="checkbox"/> Vaginal	<input type="checkbox"/> Hormone Tx	<input type="checkbox"/> Already Diagnosed	_____
LMP ____/____/____	<input type="checkbox"/> Abnormal Bleeding	Type: _____	_____
Menses	<input type="checkbox"/> Hysterectomy	_____	_____
<input type="checkbox"/> Regular <input type="checkbox"/> Postmenopausal	CONTRACEPTION	<input type="checkbox"/> Post Radiation	_____
<input type="checkbox"/> Irregular	<input type="checkbox"/> ORAL <input type="checkbox"/> DEPO	<input type="checkbox"/> Post Chemotherapy	_____
	<input type="checkbox"/> PATCH <input type="checkbox"/> IUD		
	<input type="checkbox"/> Other _____		

DNA Probe	GC/Chlamydia <input type="checkbox"/>
Reflex HPV <input type="checkbox"/>	Pregnancy <input type="checkbox"/> Screening <input type="checkbox"/>
No HPV <input type="checkbox"/>	Sign/Symptom _____ Other _____

Special Instructions / Comments	*****LAB USE ONLY*****
STAT ____ ROUTINE ____ FROZEN ____ CALL RESULTS ____	Access No. _____
	Date Rec'd ____/____/____

DEFINITION OF "HIGH RISK" PATIENT:

- A. The patient is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or some other abnormality during any of the preceding three years; or
- B. Regardless of the patient's age, she is considered to be at high risk of developing cervical or vaginal cancer due to at least one of the following factors:
 - 1. early onset (under 16 years of age) of sexual activity;
 - 2. multiple sexual partners (five or more to date);
 - 3. history of a sexually transmitted disease (including HIV infection);
 - 4. fewer than three negative PAP smears within the previous seven years; or
 - 5. mother took DES (diethylstilbestrol) during pregnancy with patient.

MEDICARE PATIENT ADVANCE BENEFICIARY NOTICE
(Beneficiary Signature Required)

If the Medicare beneficiary believes her current "screening PAP smear" WILL BE covered by Medicare Part B:

I have been notified by _____ (name of Physician) that Medicare will deny payment for my current screening PAP smear if: (a) I have had one paid for by Medicare within the last two years, and neither condition (b) nor (c) hereafter applies; (b) I am not of childbearing age, or, if of childbearing age, I have not been diagnosed within the past three years to have cervical or vaginal cancer or some other female reproductive system abnormality; (c) my attending physician does not consider me to be at high risk for cervical or vaginal cancer; or (d) condition (b) or (c) applies, but Medicare has paid for a screening PAP smear on my behalf within the last 11 months. I believe that I am eligible to have Medicare pay for my current screening PAP smear, since I do not believe any of the preceding conditions that would cause Medicare to deny payment apply to me. If I am mistaken and Medicare denies payment for my current screening PAP smear, I agree to be personally and fully responsible for payment.

Beneficiary Signature: _____

If the Medicare beneficiary believes her current "screening PAP smear" WILL NOT BE covered by Medicare Part B:

I have been notified by _____ (name of Physician) that Medicare will deny payment for my current screening PAP smear if: (a) I have had one paid for by Medicare within the last two years, and neither condition (b) nor (c) hereafter applies; (b) I am not of childbearing age, or, if of childbearing age, I have not been diagnosed within the past three years to have cervical or vaginal cancer or some other female reproductive system abnormality; (c) my attending physician does not consider me to be at high risk for cervical or vaginal cancer; or (d) condition (b) or (c) applies, but Medicare has paid for a screening PAP smear on my behalf within the last 11 months. I believe that I am not eligible to have Medicare pay for my current screening PAP smear because I believe one or more of the preceding conditions that would cause Medicare to deny payment applies to me. If Medicare denies payment for my current screening PAP smear, I agree to be personally and fully responsible for payment.

Beneficiary Signature: _____