

Facility Name

Facility Address

Provider Full Name

Provider NPI

STAT  DUPLICATE REPORT TO:

GYNECOLOGICAL CYTOLOGY REQUEST		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	RACE	SEX
SOCIAL SECURITY NUMBER		
PATIENT ID#		

BILLING INFORMATION	
PATIENT ADDRESS	APT. #
CITY	STATE ZIP
HOME PHONE#	WORK PHONE#
BILL TO (PLEASE SELECT)	
<input type="checkbox"/> DOCTOR <input type="checkbox"/> PATIENT <input type="checkbox"/> CHP <input type="checkbox"/> MCR <input type="checkbox"/> MCD <input type="checkbox"/> OTHER	
PRIMARY INSURANCE NAME	

ADDRESS	
INSURED NAME	
ID #	GROUP #

LAB USE ONLY	
<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> SAT <input type="checkbox"/> ADEQUATE T-ZONE <input type="checkbox"/> UNSAT <input type="checkbox"/> INSUFF. T-ZONE
	PREV: BX:
CYTOTECH/DATE	
<input type="checkbox"/> AGREE WITH CYTOTECH	

SPECIMEN INFORMATION
DATE TAKEN: _____ / _____ / _____
<b>SPECIMEN SOURCE (REQUIRED)</b>
<input type="checkbox"/> CERVIX <input type="checkbox"/> VAGINAL <input type="checkbox"/> ENDOCERVIX <input type="checkbox"/> OTHER
<b>LIQUID BASED PAP ANCILLARY TESTS BY PCR:</b>
<input type="checkbox"/> WOMEN < AGE 30 (PAP ONLY) - REFLEX TO HIGH RISK HPV: <input type="checkbox"/> IF ASCUS <input type="checkbox"/> IF ABNORMAL <input type="checkbox"/> WOMEN ≥ AGE 30 (HIGH RISK HPV + PAP) <input type="checkbox"/> HIGH RISK HPV REGARDLESS <input type="checkbox"/> HIGH RISK HPV ONLY - NO PAP <input type="checkbox"/> CHLAMYDIA & G.C. <input type="checkbox"/> TRICHOMONAS
<small>ALL HIGH RISK HPV TESTING INCLUDES GENOTYPING (16/18) WHEN PERFORMED AT KWB LAB</small>
<b>SWAB OR URINE ANCILLARY TESTS BY PCR:</b>
<input type="checkbox"/> STI PANEL (INCLUDES ALL LISTED BELOW) <input type="checkbox"/> CHLAMYDIA & G.C. <input type="checkbox"/> TRICHOMONAS <input type="checkbox"/> M. GENITALIUM

CLINICAL INFORMATION
<b>ICD-10 CODES - REQUIRED</b>
<input type="checkbox"/> Z12.4 CERVIX (ROUTINE CERVICAL PAP TEST) <input type="checkbox"/> Z01.419 ROUTINE GYN EXAM <input type="checkbox"/> Z12.72 SPECIAL SCREENING FOR MALIGNANT NEOPLASM, VAGINA <input type="checkbox"/> Z87.42 PREVIOUS ABNORMAL PAP TEST <input type="checkbox"/> Z87.410 HISTORY OF CERVICAL DYSPLASIA <input type="checkbox"/> OTHER: _____
<b>LMP:</b> _____ / _____ / _____
<input type="checkbox"/> PREGNANT <input type="checkbox"/> HORMONE REPLACEMENT THERAPY <input type="checkbox"/> POST PARTUM <input type="checkbox"/> BIRTH CONTROL PILLS <input type="checkbox"/> POST MENOPAUSAL <input type="checkbox"/> DEPOPROVERA <input type="checkbox"/> ABNORMAL BLEEDING <input type="checkbox"/> IUD <input type="checkbox"/> HYSTERECTOMY <input type="checkbox"/> BIRTH CONTROL RING <input type="checkbox"/> HPV VACCINE <input type="checkbox"/> RADIATION THERAPY/DATE: _____
<b>HISTORY OF ABNORMAL PAP / BX</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>LAST PAP TEST:</b> DATE: _____ PATH#: _____
DIAGNOSIS: _____
<b>CLINICAL DIAGNOSIS:</b> _____

FOR BARCODE LABEL ONLY


**A. Notifier:** \_\_\_\_\_

**B. Patient Name:** \_\_\_\_\_

**C. Identification Number:** \_\_\_\_\_

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn't pay for **D.** \_\_\_\_\_ 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 **D.** \_\_\_\_\_ below.

<b>D.</b>	<b>E. Reason Medicare May Not Pay:</b>	<b>F. Estimated Cost:</b>
Pap Test	Less than two years since last negative Pap	\$50.00
CT/NG Test	Not indicated for patient's age or other criteria	\$250.00
HPV Test	Not indicated for patient's age of other criteria	\$250.00

**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 **D.** \_\_\_\_\_ 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.

<b>G. Options:      Check only one box. We cannot choose a box for you.</b>
<p>____ <b>OPTION 1:</b> I want the <b>D.</b> _____ 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 <b>I can appeal to Medicare</b> 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.</p> <p>____ <b>OPTION 2:</b> I want the <b>D.</b> _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b></p> <p>____ <b>OPTION 3:</b> I don't want the <b>D.</b> _____ listed above. I understand with this choice I am <b>not responsible for payment, and I cannot appeal to see if Medicare would pay.</b></p>

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice of 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 may request a copy.

<b>I. Signature:</b> _____	<b>J. Date:</b> _____
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Physician's Name: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Accession Number: \_\_\_\_\_