

CYTOLOGY PAP TEST REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)			CLIENT INFORMATION			
Last Name	First	MI	ORDERING PHYSICIAN CONTACT Physician Name _____ Physician Signature _____ Physician NPI# _____ Physician Phone _____ Physician Email _____ <input type="checkbox"/> Call Results to phone number: (_____) _____ <input type="checkbox"/> Fax report to: (_____) _____			
Address	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F				
City	SS #					
State	Zip	Home Phone				
Hospital/Physician Office Patient ID #	Accession #					
MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.						
INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)						
BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient						
PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____						
PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child						
Subscriber Last Name	First	MI				
Beneficiary / Member #	Group #					
Claims Address	City	State				Zip
SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) ABN: <input type="checkbox"/> No <input type="checkbox"/> Yes						
DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____						
GYNECOLOGIC (PAP TEST)		INDICATIONS FOR PAP TEST		ADDITIONAL TESTS (LIQUID-BASED ONLY)		
<input type="checkbox"/> ThinPrep™ <input type="checkbox"/> Smear <input type="checkbox"/> Surepath		<input type="checkbox"/> Screening Pap: routine <input type="checkbox"/> Screening Pap: high risk of cervical cancer <input type="checkbox"/> Diagnostic Pap Smear LMP: _____ Previous Pap Date: _____ Result: _____ (ABN IS REQUIRED IF PREVIOUS PAP IS LESS THAN 2 YEARS AGO)		<input type="checkbox"/> Reflex HPV typing for ASCUS result (76557-HPV) (83741-HPVSP) (IF REFLEX HPV TYPING IS CHECKED, THE SAMPLE WILL BE SENT FOR HPV TYPING ONLY IF CURRENT PAP IS ASCUS) <input type="checkbox"/> Automatic HPV typing (76557-HPV) (83741-HPVSP) <input type="checkbox"/> GC/Chlamydia Amplification (79830-GCCT) <input type="checkbox"/> Chlamydia Amplification (79809-CT) <input type="checkbox"/> CG Amplification (79810-GC) <input type="checkbox"/> No additional testing		
Collection Date/Time: _____						
SOURCE: <input type="checkbox"/> Cervix/Endocervix Vagina: <input type="checkbox"/> Vault <input type="checkbox"/> Wall						
CLINICAL (CHECK ALL THAT APPLY TO GYN)						
<input type="checkbox"/> Routine Exam <input type="checkbox"/> Pregnant _____ wks <input type="checkbox"/> Postpartum _____ wks <input type="checkbox"/> Post Menopausal <input type="checkbox"/> Post Abortion <input type="checkbox"/> Abnormal Bleeding		<input type="checkbox"/> Hysterectomy, total <input type="checkbox"/> Hysterectomy, subtotal <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Cervix Conization <input type="checkbox"/> Cryolaser		<input type="checkbox"/> Cryo of Cervix <input type="checkbox"/> Hormone Replacement Therapy <input type="checkbox"/> Oral Contraceptives <input type="checkbox"/> DES Exposure <input type="checkbox"/> IUD <input type="checkbox"/> Colposcopy		
				<input type="checkbox"/> History of Malignancy (please describe) Site: _____ _____ _____ _____		