GYN CYTOLOGY ADD-ON TESTING REQUEST

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Place patient label here

CLIENT INFORMATION

Request Date: ____________________ Vista Accession#: __________________

Ordering Provider: ______________________________

Clinic Name: ______________________________

Address: ______________________________

____

Phone: ____________________ Fax: ____________________

☐ Copy Report to:

Name(s): ____________________

____

Collection Date: ____________________

PATIENT INFORMATION

Name: ______________________________

DOB: ____________________ Gender: ☐ F ☐ M ☐ Unspecified

Billing Information:

- ☐ Insurance
- ☐ Patient
- ☐ Medicare
- ☐ OHP
- ☐ Other: ____________________

____

Menstrual Status:

- ☐ LMP ____________
- ☐ Pregnant
- ☐ Postpartum
- ☐ Menopausal
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Supracervical

Please attach detailed billing information separately (including patient address, phone number and insurance information).

Clinical History:

- ☐ Normal history
- ☐ Prior abnormal Pap/HPV/Biopsy
- ☐ Abnormal bleeding
- ☐ IUD
- ☐ Hormone tx (replacement or contraception)
- ☐ Visible lesion on exam
- ☐ Other: ____________________

SPECIMEN INFORMATION

Test Type/ICD-10 Codes (required):

- ☐ Routine cervical screening **Z12.4**
  Medicare coverage q 2 years
- ☐ Routine vaginal screening **Z12.72**
  Medicare coverage q 2 years
- ☐ Routine vaginal screening history of malignancy of other site (not cervix) **Z12.89**
  Medicare coverage q 2 years
- ☐ Screening for high risk pt **Z91.89**
  Medicare coverage yearly
- ☐ Diagnostic Pap - Medicare covers as medical necessity but must give ICD-10:
  - ☐ **N87.0** Dysplasia (not CIN3/CIS)
  - ☐ **D06.9** CIN3/CIS
  - ☐ **R87.820** Abnormal Pap/HPV
  - ☐ **N72** Cervicitis
  - ☐ **N76.0** Vaginitis
  - ☐ **N93.8** Abnormal uterine bleeding
  - ☐ **N95.0** Post-Menopausal bleeding
  - ☐ **N89.8** Vaginal discharge
  - ☐ **A60.00** Genital Herpes
  - ☐ **C53.1** Malignant neoplasm cervix
  - ☐ **C54.1** Malignant neoplasm endometrium
  - ☐ **Z34.__ __** Pregnancy
  - ☐ Other: ____________________

Specimen Site (required):

☐ Cervical/endocervical ☐ Vaginal ☐

Please check the applicable Add-on testing:

- ☐ High Risk HPV testing
- ☐ High Risk HPV testing + reflex genotyping (16, 18/45)
- ☐ HPV Genotyping (16, 18/45)

NOTE

ADVANCE BENEFICIARY NOTICE (ABN)

ABN must be completed, signed and dated for all Medicare patients

SEE OTHER SIDE OF THIS SHEET.