

*****GYN CYTOLOGY ADD-ON TESTING REQUEST*****



1032 E. Jackson Street
 Medford, OR 97504
 ph: 541-770-4559
 fax: 541-770-4511
 www.vistapathology.com

Place patient label here

Gynecologic Cytology (Pap) / HPV / STI Test Requisition

CLIENT INFORMATION

Request Date: _____ Vista Accession#: GYC Copy Report to:
 Ordering Provider: _____ Name(s): _____
 Clinic Name: _____
 Address: _____
 Phone: _____ Fax: _____ Collection Date: _____

PATIENT INFORMATION

Name: _____
 DOB: _____ Gender: F M Unspecified
Billing Information:
 Insurance OHP
 Patient Other: _____
 Medicare _____

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

SPECIMEN INFORMATION

<p>Test Type/ICD-10 Codes (required):</p> <input type="checkbox"/> Routine cervical screening Z12.4 <i>Medicare coverage q 2 years</i> <input type="checkbox"/> Routine vaginal screening Z12.72 <i>Medicare coverage q 2 years</i> <input type="checkbox"/> Routine vaginal screening history of malignancy of other site (not cervix) Z12.89 <i>Medicare coverage q 2 years</i> <input type="checkbox"/> Screening for high risk pt Z91.89 <i>Medicare coverage yearly</i> <input type="checkbox"/> Diagnostic Pap - Medicare covers as medical necessity but must give ICD-10: <input type="checkbox"/> N87.0 Dysplasia (not CIN3/CIS) <input type="checkbox"/> D06.9 CIN3/CIS <input type="checkbox"/> R87.820 Abnormal Pap/HPV <input type="checkbox"/> N72 Cervicitis <input type="checkbox"/> N76.0 Vaginitis <input type="checkbox"/> N93.8 Abnormal uterine bleeding <input type="checkbox"/> N95.0 Post-Menopausal bleeding <input type="checkbox"/> N89.8 Vaginal discharge <input type="checkbox"/> A60.00 Genital Herpes <input type="checkbox"/> C53.1 Malignant neoplasm cervix <input type="checkbox"/> C54.1 Malignant neoplasm endometrium <input type="checkbox"/> Z34. __ __ Pregnancy <input type="checkbox"/> Other: _____	<p>Please check the applicable Add-on Testing: (Specimens are typically held up to 30 days, storage space permitting)</p> <p>HPV EVALUATION</p> <input type="checkbox"/> High Risk HPV Testing ONLY <input type="checkbox"/> High Risk HPV Testing + reflex genotyping (16, 18/45) <input type="checkbox"/> HPV Genotyping ONLY (for confirmed HPV positive cases) <p>MOLECULAR ANCILLARY TESTING</p> <input type="checkbox"/> N. gonorrhea/C. trachomatis ONLY available if one of the following conditions are met: <ul style="list-style-type: none"> • APTIMA Multitest Swab was submitted originally (and still available) • Other Molecular/HPV testing was completed previously on ThinPrep <input type="checkbox"/> Vaginitis Panel (only available if APTIMA Multitest Swab was provided)
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NOTE **ADVANCE BENEFICIARY NOTICE (ABN)**
 ABN must be completed, signed and dated for all Medicare patients
 SEE OTHER SIDE OF THIS SHEET.

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** items and services 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.** items and services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Screening Pap, (Pap may require pathologist interpretation, possible HPV testing) Chlamydia, Gonorrhea, Herpes Simplex Virus 1 & 2, Vaginitis testing	Frequency of Pap or HPV testing could exceed Medicare limits	\$30-\$700, depending on extent of testing

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.** items and services 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 **D.** items and services 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 **D.** items and services 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 **D.** items and services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. 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.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.