THE PATHOLOGY LABORATORY

DRS. STEVENS, BURTON, EAPEN, KELLY, PRIMEAUX, RICHARD,
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PLEASE ATTACH PATIENT FACESHEET

TISSUE/PAP REQUEST FORM

FILL OUT COMPLETELY AND SUBMIT WITH SPECIMEN DATE:

CHART NO.	NAME OF PATIENT - PREVIOUS LAST NAME IF CHANGED	D.O.B. (REQUIRED)	SEX	RACE	PHONE#
NECESSARY IF BILLED TO PATIENT MEDICARE/MEDICAID	ADDRESS OF PATIENT	CITY, STATE, ZIP CODE			

SOCIAL SECURITY# (REQUIRED): ____________ **MEDICARE#:** ____________

MEDICAID#: ____________ **CARD ISSUE DATE:** ____________

PHYSICIAN:	**ICD-9 DIAGNOSIS:**
PREVIOUS DIAGNOSIS and DATE:	**CLINICAL HISTORY:**

SPECIMEN:

PAP SMEAR FROM: **CERVIX** **ENDOCERVIX** **VAGINA**
(CIRCLE ONE)

LMP (REQUIRED):

CYTOPATHOLOGY CLINIC HISTORY *(CIRCLE RESPONSES)*			
	PREGNANT	IRREGULAR MENSES	PELVIC RADIATION
	POST PARTUM	HYSTERECTOMY	OTHER: ________
	BIRTH CONTROL	INTRAUTERINE DEVICE	________
	ESTROGEN THERAPY	VAGINAL IRRITATION	________
	POST MENOPAUSAL		

ADDITIONAL TESTS REQUESTED ON THIN PREP PAP:

- ☐ 1 TRICHOMONAS
- ☐ 2 CHLAMYDIA & GONORRHEA
- ☐ 3 HPV IF ABNORMAL
- ☐ 4 HPV: REGARDLESS OF PAP RESULT
- ☐ 5 HPV FOR AGE 30 AND OVER

Please Include copy of front and back of Patient's insurance card with form.

ASSIGNMENT OF BENEFITS

Patient/Guarantor assumes all rights, title and interest and authorizes direct payment to The Pathology Laboratory of any insurance benefits for the laboratory testing.

MEDICARE PATIENTS HAVING A PAP SMEAR PERFORMED MUST READ AND SIGN REVERSE

LCP93290

A. The Pathology Laboratory

MEDICARE PATIENTS MUST READ AND SIGN

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (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.

D. **Laboratory Tests**	**E.** **Reason Medicare May Not Pay:**
Pap Smear ($22 - $50) Thin Prep ($65-$95) HPV ($127) Flow Cytometry ($300 - $550) Chlamydia/Gonorrhea ($186) Trichomonas Molecular ($93)	1. Medicare does not pay for these tests as often as this. (Denied as too frequent) or 2. Medicare does not pay for these tests for your condition.

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.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.**____________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.**______________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.**___________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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