# DPMG CYTOLOGY/MOLECULAR TESTING REQUISITION FORM


DIAGNOSTIC PATHOLOGY MEDICAL GROUP, INC.

**Customer Service and Courier Pickup**
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Form completed by: _____

*Please fill out this form completely and place completed specimen label sticker on each container*

Additional Copies of Report To (Name and Address): _____

| Patient Name: Last, First | | | Date Specimen Taken |
|---|---|---|---|
| Patient Address | City | Zip Code | Telephone Number |
| Date of Birth | Age | Sex | SSN |

## GYN PAP TESTING

- ☐ SurePath
- ☐ ThinPrep
- ☐ Conventional Slide
  # of slides _____

**SOURCE**
- ☐ Vaginal
- ☐ Cervical
- ☐ Endocervical

## HPV HIGH RISK SCREEN (CHECK ONLY ONE)

☐ Follow ACOG age related HPV testing guidelines
Age 21-29 Pap with reflex HPV if Pap ASCUS
Age 30-65 Pap with HPV (co-testing) if Pap neg & HPV pos, reflex HPV 16, 18/45

## GYN HISTORY

LMP Date _____
- ☐ Post Partum
- ☐ Post/Peri Menopausal
- ☐ Contraceptive
- ☐ Pregnant
- ☐ IUD

## ALTERNATIVE HPV TESTING OPTIONS

- ☐ HR HPV regardless of Pap result or age
- ☐ HR HPV if Pap is ASCUS/ASC-H
- ☐ HR HPV if Pap is Abnormal
- ☐ HR HPV only (no Pap)

Reflex HPV Genotyping 16, 18/45 if:
(check only one as needed)
- ☐ HPV positive
- ☐ HPV positive and Pap negative (per ASCCP guidelines)

## MOLECULAR TESTING (From Pap Vial or Aptima Swab)

- ☐ Vaginitis: CV (Candida species & C. Glabrata) BV (Gardnerella & Lactobacillus) & Trich
- ☐ Vaginitis + Chlamydia, Gonorrhea
- ☐ Chlamydia, Gonorrhea
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Trichomonas

## (Other)

- ☐ Urine
  - ☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas
- ☐ BD Affirm Swab (Candida, Gardnerella, Trichomonas)

### Common ICD-10 Codes (Circle One)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abnormal Pap | R87.619 | Irreg Periods | N92.6 | Vaginitis Atrophic | N95.2 | Screen for Malig Neo | Z12.4 |
| Cervicitis | N72 | Vag Discharge | N89.8 | Pelvic Pain | R10.2 | Gyn exam w/abnormality | Z01.411 |
| Post Menop Bleeding | N95.0 | Vaginitis | N76.0 | HPV Screening | Z11.51 | Gyn exam w/o abnormality | Z01.419 |
| Hx of Malig Neoplasm | Z85.9 | | | | | Other _____ | |

## Non-GYN Specimen - Please check one

Ascitic: ☐ Breast: R ☐ L ☐ CSF: ☐ Brush/Wash: ☐ (Specify Site) _____
Sputum: ☐ Other: ☐ (Specify) _____

## Urine Cytology/FISH (UroVysion) - Please check one

☐ Cytology ☐ Cytology/FISH ☐ Cytology/reflex FISH (atypical results) ☐ FISH only

***ICD-10 Diagnosis Code (Required for all specimen referrals):*** _____

CLINICAL DATA: _____

INSURANCE ☐ Copy of insurance card(s) attached ☐ Cash pay patient

**If Medicare is likely to deny payment for the test(s) ordered, please submit a copy of the patient's signed ABN or complete the ABN on the backside of this requisition.**

*Patient full name required - Place completed specimen label sticker on each container*

Name _____ (Last/First)
Date _____
Specimen C00408371-1

Name _____ (Last/First)
Date _____
Specimen C00408371-2

C00408371-3

Notifier(s):
Patient Name: Identification Number:

# ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

*NOTE:* If Medicare doesn't pay for the Lab Test 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 Lab Test below.

| *Lab Test* | Reason Medicare May Not Pay: | Estimated Cost: |
|---|---|---|
| ❒ 88142 Thin Prep Pap Smear | Medicare does not pay for this test as often as this (denied as too frequent) | $55.00 |
| ❒ 88175 Thin Prep Pap Smear, automated screening | | $64.47 |
| ❒ 88164 Conventional Pap Smear | | $31.00 |
| ❒ 88141 Path Screening / Atypical | | $45.86 |
| ❒ 87621 HPV testing | | $85.42 |

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 Lab Test 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.

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

❒ **OPTION 1.** I want the Lab Test listed above. You may ask to be paid now, but I will 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 does not 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 Lab Test 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 Lab Test listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

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.

| **Signature:** | **Date:** |
|---|---|
| | |





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